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UNIVERSITY OF ALBERTA

NURSES AND PRIMARY HEALTH CARE IN NEPAL

by

©

Linda Ogilvie

A thesis submitted to the Faculty of Graduate Studies in partial fulfilment of the requirements for the degree of Doctor of Philosophy

in

International/Intercultural Education

Department of Educational Foundations

Edmonton, Alberta
Fall 1993

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ISBN 0-315-88329-4

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Dedication

This dissertation is dedicated to the nurses in Nepal, many of whom gave freely of their time, experiences, thoughts and feelings. Without their co-operation and interest, this project could not have been completed.

Abstract

Since the Declaration of Alma-Ata in 1978, Primary Health Care has been promoted by the World Health Organization as the best strategy for achieving the goal of "Health For All by the Year 2000". Implicit within the concept of Primary Health Care, with its orientation towards a focus on health rather than disease, is recognition that the roles of health professionals may change. Nurses worldwide seem aware that opportunities may exist for the nursing profession to achieve greater autonomy at the clinical level and greater participation at the health care planning and policy level. These opportunities may be mediated by the national contexts within which nurses practise. A case study of the employment and education of nurses in Nepal was conducted in order to ascertain the forces shaping nursing contributions to Primary Health Care in the Nepalese context. Government and other official health documents were examined. The seven schools of nursing in the country were visited and questionnaires were completed by nursing students and faculty. Forty-four co-researchers (43 were nurses) were interviewed. Nursing curricula (bachelor and certificate levels) developed and implemented in the 1980s (with a focus on preparing nurses for Primary Health Care roles) were examined and compared with preceding curricula. What emerged from the data was an appreciation of the complexity of the forces conditioning nursing efficacy in the Nepalese context. While there are few community health positions for nurses within the government health services, nurses appear optimistic for the future. Four categories of forces, related to a core concept of "readiness", appear to mediate nursing efficacy in Nepal. Categories and concepts that were identified include: individual forces (consciousness, confidence, competence, commitment, challenge); professional forces (cohesion, credibility, collegiality, voice,

responsiveness to societal needs, legal status); societal forces (infrastructure development, political will, economic feasibility, respect); and international forces (opportunity, solidarity, technological and financial support). Many of the issues identified by Nepalese nurses were similar to issues confronting nurses in Canada although the specific problems were different.

Preface

The presentation of this research has been structured with the intent of facilitating audibility, a criterion for assessing the quality of qualitative research findings. This feature "is achieved when the researcher leaves a clear decision trail concerning the study from its beginning to its end" (Sandelowski, 1986, p. 34).

The background to the study, including introduction of the research questions, is outlined in Chapter 1. The literature review in Chapter 2 is intended to stimulate theoretical sensitivity to issues which appeared relevant to the research problem. No preconceived theoretical framework was developed as little research has been done on the context in which nurses work and it might condition selection of data. A section labelled reflections on the contents completes Chapter 2 and all succeeding chapters. It includes summary, conclusions and comment regarding the important points. A literature review of the general Nepalese context is presented in Chapter 3. The section on the health care system in Nepal includes discussion of the model of Primary Health Care in Nepal, thus answering the first research question. Discussion of the research process is in Chapter 4.

The findings and analysis are presented in chapters 5 to 9. Drawn primarily from documents accessed in Nepal, the development of human resources for health is the focus of Chapter 5. The development of nursing in Nepal is placed in historical perspective. The research question pertaining to the nursing role in Primary Health care is addressed.

In Chapter 6, nursing initiatives in Primary Health Care are outlined. The focus is on nursing education as there have been few positions for professional level nurses in government health services outside of traditional hospital roles. Student responses to questions regarding nursing roles and involvement, drawn from analysis of open-ended questionnaire items, are included. The third research question, regarding changes in nursing education in response to the focus on Primary Health Care, is dealt with in Chapter 6.

Social and professional profiles of nursing students and faculty, drawn from questionnaire responses, are presented in Chapter 7. Some of this data is related to social variables introduced in the discussion of the Nepalese context in Chapter 3.

Issues confronting nurses in Nepal, as perceived by the nurses and revealed in the interviews, are discussed in Chapter 8. This content addresses the fourth research question.

The fifth research question, regarding structural features both enabling and constraining effective nursing involvement in Primary Health Care in Nepal, is addressed in Chapter 9 where a synthesis of data from all sources has led to the development of concepts towards a theory of nursing efficacy. What became evident from the data was the importance of both structural and agency forces in mediating nursing efficacy. The forces shaping nursing contributions to Primary Health Care are the forces mediating nursing efficacy and include individual, professional, societal and international forces.

This is a case study in which multiple methods of data collection and analysis have been used in developing the final construal. While a framework for assessing nursing efficacy is suggested, it must be emphasized that the framework has been developed from a single case. To suggest that a grounded theory has been developed would be a misnomer. Replication of the method in other contexts would allow generation of additional data from which a grounded theory on nursing efficacy could be constructed.

Acknowledgements

Many people have contributed in unique ways to the successful completion of this research. I have appreciated all of their assistance. Of utmost importance has been the support and encouragement of my committee. Dr. M. K. Bacchus reinforced my wish to do fieldwork outside of Canada and was facilitative during each stage of the research process. Dr. R. Pannu provided critical insights during proposal development. Dr. J. Kerr consistently reinforced that my work had merit and thus provided much appreciated encouragement. Professor K. Dier shared resources and insights from her expertise in international nursing. Dr. M. Assheton-Smith articulated her impressions of conditions in Nepal. Dr. C. Urion stimulated thought and discussion by his highly reflective questions during oral examinations. From her experience in Nepal, Dr. S. Robinson was able to address the role of external examiner from the vantage points of both academic scholar and knowledgeable reviewer of contextual issues.

Supportive in a different but very concrete way has been the financial assistance received from the Social Sciences and Humanities Research Council of Canada (Doctoral Fellowship), the International Development Research Centre (Young Canadian Researchers Award) and the University of Alberta (Walter H. Johns Graduate Fellowship). Without this financial support the cost of data collection in Nepal may have been prohibitive. I would also like to thank Dr. M. Wood, Dean of the Faculty of Nursing at the University of Alberta, for facilitating my leave of absence. It was a luxury to be able to devote so much time to the pursuit of a PhD. Colleagues from the Faculty of Nursing were supportive in numerous ways.

In Nepal, data collection was facilitated by Dr. Uma Devi Das, Director of the Nursing Education Unit at the Institute of Medicine for Tribhuvan University. Entry into the research setting was supported by Dean Prasai at the Institute of Medicine. Judith O'Heir, WHO Nursing Education Advisor for Nepal, was instrumental in connecting me with the appropriate people. I would also like to acknowledge the support of the Campus Chiefs at all seven schools of nursing for certificate level students. The contributions of all persons who were interviewed or completed questionnaires is appreciated. The friendship of Meena and Milan Rajbhandari, their family and the staff at Hotel Karnali, which was my base for six months, made living in Kathmandu very easy.

My family supported the decision to pursue a PhD and my parents assisted with financial support. My sister Gail typed numerous funding proposals. I would like to thank all of them.

Friends were very important in encouraging my work. The ABD Group (all but dissertation) of primarily nursing faculty engaged in PhD study met monthly during my analysis and writing of data. I particularly wish to acknowledge the contributions of Lynn Skillen (academic insights and personal support) and Wendy Hurtig (who carried some of my research data from Nepal to Canada and missed her connection in Vancouver in order to trace the missing luggage). Friends who have been associated with CUSO and classmates from developing countries were invaluable in discussions of how to approach the research.

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LIST OF ABBREVIATIONS

PHC	Primary Health Care
HFA	Health For All
WHO	World Health Organization
ICN	International Council of Nurses
NGO	Nongovernmental Organization
UMN	United Missions to Nepal
VSO	Volunteer Services Overseas
GDP	Gross Domestic Product
GNP	Gross National Product
CHL	Community Health Leader
HA	Health Assistant
CMA	Certified Medical Assistant (Auxiliary Health Worker)
VHA	Village Health Worker
ANM	Assistant Nurse Midwife
BN	Bachelor in Nursing
PHN	Public Health Nurse

CHAPTER 1: THE IMPORTANCE OF CONTEXT

Since the Declaration of Alma-Ata in 1978 (Appendix 1), Primary Health Care has been promoted by the World Health Organization (WHO) as the best strategy for achieving the goal of "health for all by the year 2000". By definition:

> Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (World Health Organization, 1988a, p.8)

Dr H. Mahler, former Director-General of WHO, was careful to articulate that: "Social goals vary by country - there is no universal model, as history has so dramatically illustrated - and so must the shape of health development vary by country .... Each country has to determine its own health system in the light of its political, social and economic realities" (World Health Organization, 1988a, p. 4). The context will influence the pattern of health care in specific nations. Thus the purpose of this research is the illumination of the context in which the transition to Primary Health Care is occurring in Nepal.

Definition of the Problem

The importance of the Alma-Ata declaration in shifting health priorities from a disease-oriented and curative perspective to a perspective emphasizing prevention, health promotion and risk management cannot be ignored. The implications for practice, education and research are significant for all health professionals and auxiliaries. The implementation of effective health care systems congruent with the principles of Primary Health Care requires far-reaching structural changes in how services are supplied and changes in the skills needed by the health workers providing guidance and care. For this reason, the World Health Organization (1988b) has given priority to research on health policy and organizational behaviour and has recently acknowledged that nurses may be the key health professionals in the implementation of the Primary Health Care concept.

Not acknowledged in the World Health Organization literature is recognition that implementation of the principles of Primary Health Care implies far-reaching structural changes not only in the distribution of health resources but also in the power relations within society and within the institutionalized structure of control of prevailing systems of health care.

The successful transition to a Primary Health Care model is predicated on four assumptions:

(i) the presence of the political will to distribute resources according to criteria of social justice, equity and need,

(ii) the willingness of health care providers to develop manpower strategies designed to meet the needs of individuals and communities without engaging in territorial power struggles,

(iii) the participation of individuals and communities in defining needs and proposing solutions, and

(iv) the recognition that health and health care are not synonymous concepts.

Underlying the blueprint for Primary Health Care is a model for social change. Primary Health Care is a philosophical stance and a methodology in which the theoretical, historical and contextual antecedents have been omitted. Whether the omissions are deliberate or inadvertent is of little relevance to the research being proposed; the material significance of these omissions for addressing the research questions is considerable.

At the philosophical level, Primary Health Care involves a commitment to health as a fundamental human right with health defined broadly as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organization, 1988a, p.7). Implicit in this stance is universal access to adequate means to satisfy basic human needs. Inequalities in the health status of populations are deplored. There is an appreciation that social conditions influence health status and that sociocultural and economic inequities predispose populations within countries and across countries to wide variations in health parameters. As a philosophy, Primary Health Care could be viewed as a radical document demanding attention to issues of social justice.

As a methodology, the radical implications are often overlooked as the social justice implications may be subordinated to decisions relating the investment of scarce resources to maximal returns as measured by national rather than regional and local decreases in morbidity and mortality indices. Cross-national disparities are viewed as problems of underdevelopment in specific nations rather than as a global issue related to international power structures and inequitable distribution of the world's resources. There appears to be a belief entertained in circles with the responsibility for formulating the Primary Health Care model that the international community has a commitment to development and that equitable distribution of resources will be achieved consensually as a consequence of capitalist development and international cooperation. This research approach views this rather benign assumption with skepticism.

It is argued that various interest groups condition the effectiveness of the model of Primary Health Care adopted in a specific political, economic and sociocultural context. Nurses may occupy a key position, either as leaders or as pawns, because of the support provided by the World Health Organization. While the WHO support is not overwhelming, there appears to be an openness to nursing participation at leadership levels which has been lacking in the past. Nurses may be able to take advantage of this opportunity in order to manoeuvre new roles and responsibilities for the profession. In view of the possibility of sweeping changes in health care policy in developed and developing countries, it was decided to look at nursing in some depth in one developing country for reasons which will be articulated below.

Conceptualization of the Research Process

The decision to do a case study about nurses and Primary Health Care in Nepal evolved from an initial concern about the direction of current trends in international nursing and the lack of research findings to guide nurses, primarily from the more industrialized countries, who are engaged in international endeavours. While nurses employed by WHO have had access to much relevant information, "the need for discretion prohibited publication of articles or photographs and this is probably why so little has been written about the service" (Dier, 1992, p. 204). Five phases of international nursing practice have defined the relationships between nurses from the more developed to the less developed nations: doing phase, training phase, supporting phase, consulting phase and collaborating phase

(Dier, 1992). The first three phases involved providing nursing care, educating nursing personnel and working as counterparts to initiate indigenous nurses into nursing leadership roles. In these phases nurses remained in host countries for prolonged periods of time. There was time to learn about national and local contexts before making changes or recommendations. The thrust of nursing involvement in recent years has focused on the consulting and collaborating phases. Consultations usually involve nurses with specific expertise who are asked to "give workshops on new developments, to establish a project or program, or to conduct feasibility or evaluation studies" (Dier, 1992, p. 208). The time frame is generally short and the nursing consultant may have little or no background in international development. The emerging model is one of collaboration or partnership with sharing of information, services and expertise being the goal. This changing nature of international nursing initiatives requires an understanding of the importance of context and a recognition of similarities and differences encountered by nurses in various countries in order to minimize ethnocentrism and domination by nurses from the more affluent nations.

Context both enables and constrains the opportunities for nurses to contribute to the health of populations. In Textbook of International Health (1990), Paul Basch provides a thoughtful overview of current knowledge, opinion and controversy in several dimensions of international health. His critique of comparative studies in health echoes concerns that have been raised in critiques of development sociology. While not negating the usefulness of comparative work, the ahistorical, acontextual and atheoretical nature of most comparative studies is lamented. In a statement which appears to paraphrase critiques of current development theory, Basch contends that: "The patterns of demographic, epidemiological, and fertility transitions of the poorer countries do not necessarily follow the path taken by today's wealthier nations. Comparisons between countries are therefore analogies, not homologies, and their utility for making predictions is limited" (p. 290).

As all member nations of the World Health Organization have signed a declaration outlining Primary Health Care as the best strategy for increasing the health status of populations worldwide, analyzing nursing participation, including nurses' perceptions of the forces influencing their role, should solicit meaningful data. It is hoped that the research approach in this case study has elicited data relevant and useful for comparative work regarding nursing issues in a crosscultural context. Nursing contributions to Primary Health Care in Nepal provide a focal point around which issues may be revealed. This research, therefore, was conceptualized on three levels: as a case study of the Nepalese context, as a test of the methodology to see if meaningful data emerge, and as a basis for comparative study of the context in which nurses work in different nations and how this context shapes the contributions they make to Primary Health Care. Replication of the study in other nursing contexts should assist in theory construction about nursing contributions under varying circumstances. Data from several nations would aid in theory construction useful for predicting nursing contributions crossculturally.

The Research Approach

In case-study research, the research design emerges from the questions being addressed (Polit & Hungler, 1978; Yin, 1989). Triangulation of qualitative and quantitative research methods seemed the most useful approach. Therefore, government documents relating to health issues were examined, data for inclusion in a questionnaire were collected and interviews were conducted. These methods were supplemented by participant observation and a diary recording my feelings and impressions of the research process and data.

An empiricist approach to the problem was rejected as I do not believe that all of reality is amenable to objective and quantifiable observation. Individual interpretations of meaning, however, may obscure reality on the societal level while still offering information about subjective impressions which add to the understanding of societal processes and of the actions which social agents perceive as possible, desirable or useful. The positivist view of science, in which the scientific task is the uncovering of universal laws from which behaviour can be predicted or controlled, was rejected in favour of a contextualist and historical approach to interpretation of social change. Neither agency (voluntarism) nor structure (determinism) received primacy in the conceptualization of the research process. Both are relevant and which is operable is contingent upon the multiplicity of forces in effect at any one point in time.

The Research Questions

To address the problem of which forces shape nursing contributions to Primary Health Care in Nepal, specific research questions were developed:

(1) What model of Primary Health Care is being implemented in Nepal?

(2) How have nurses been incorporated into the model?

(3) How has nursing education changed in response to the focus on Primary Health Care?

(4) What do nursing leaders, educators and students in Nepal identify as key issues in determining the effectiveness of nursing efforts in Primary Health Care?

(5) What are the structural features both enabling and

constraining effective nursing involvement in Primary Health Care?

In this study, nurses were defined as the personnel designated as nurses within the Nepalese context. These are the personnel who are educated and supervised under the aegis of the nursing profession and, therefore, are most directly affected by decisions about the influence, responsibility, scope, autonomy and accountability of organized nursing in Nepal. Included are assistant nurse midwives (auxiliary nurses) and certificate or higher level nurses (professional nurses). Emphasis has been placed on professional nurses.

The framework for assessing the context in which nurses practise incorporated suggestions from three sources (Beaton, 1983; Dier, 1988; Ertler, Schmidl, Tretyl & Wintersberger, 1987). General areas included:

(i) natural indicators (geography, ecology, epidemiology, demography);

(ii) technological and economic development (communication, transportation, electricity or equivalent energy source, water supply, sanitation, economic productivity indicators);

(iii) historical and sociocultural factors (lifestyles, value systems, traditions in health care, health practices, class and gender issues);

(iv) relations of production;

(v) ideological superstructure (political system, educational system, health care system); and

(vi) position regarding national independence as opposed to colonial or neocolonial dependence or interdependence (international pressures affecting national autonomy).

A detailed discussion and description of actual research procedures used is presented in chapter four.

CHAPTER 2: THE THEORETICAL CONTEXT

As little research has been done on the context in which nurses work and because of the possibility of influencing the selection of data, no preconceived theoretical framework directly guided this research. The theoretical perspectives being introduced arose from literature searches of areas which intuitively seemed relevant to the research problem, but confirmation could only emerge from the data. Decisions made regarding the relevant literature to review reveal my biases as to the potential findings and relationships among concepts. As stated by Strauss and Corbin, theoretical sensitivity to qualitative research data requires that "any theoretical explanations or categories brought to the research situation are considered provisional until supported by actual data" (1990, p. 45).

The choice of the literature reviewed here was guided by the need to stimulate theoretical sensitivity to issues in the areas of Primary Health Care, power, health and development, power and the health professions, and international influences on the nursing profession. Research-based and analytical discussions, as well as descriptive articles, in each of these substantive areas were reviewed. As the purpose of this study on nurses and Primary Health Care in Nepal was to develop a theoretical approach to the examination of context, it was important to "explain phenomena in the light of the theoretical framework that evolves during the research itself" and not "be constrained by having to adhere to a previously developed theory that may or may not apply to the area under investigation" (Strauss & Corbin, 1990, p. 49). Further literature review was undertaken during data collection and data analysis.

Primary Health Care

Concerning the philosophical basis of Primary Health Care, it appears that the theory linking philosophy to method has remained unspecified. As a methodology, Primary Health Care has many dimensions. There is recognition that health cannot be isolated from other social goals and that intersectoral collaboration in development issues is a prerequisite for positive influence on health outcomes (World Health Organization, 1986). While the Primary Health Care concept has evolved from an appreciation of illness-generating social conditions, there is little appreciation that structural changes in health systems are difficult, if not impossible, where resources are scarce and inequities in the social system are obvious (Navarro, 1986).

The Marxist concept of institutional structures, i. e. health care systems, as homologous to the social relations of production (Williams, 1980) is missing in discussions of Primary Health Care. The political power dimensions of health and health care systems are not acknowledged and the recommendations for change remain at the level of appearances. Recent articles, however, have analyzed the dimensions of equity and health (Whitehead, 1991) and the interconnections between politics, power and poverty in conditioning the health status of populations in the Third World (Green, 1991). These recent publications suggest that more research attention is beginning to be directed towards underlying forces adversely affecting efforts to provide Health For All by the year 2000.

The Primary Health Care concept appears to lack theoretical development. Philosophically, equity and social justice are stressed. The goal is specified as Health For All. The strategies for achieving the goal, however, are principles which are submitted merely as guidelines which individual nations may or may not wish to adapt to their specific needs. While wise use of scarce resources is stressed, there is no discussion of the political and sociocultural conditions under which equity and social justice may be achieved. Structural constraints are ignored. Advocated is a shift in focus from disease to health, increased access to health care, community participation in decison-making and reinforcement of the value of organized health care in improving the health status of populations.

Ignored is the political dimension of health in spite of a focus on community participation, which is interpreted as self-reliance and individual or collective responsibility, and an emphasis on governmental responsibility in providing for the health of people. There is an assumption regarding the neutrality of the health sciences and a focus on an instrumentalist solution. In the translation from philosophy to methodology, the complexity of the issues has been lost and the notion of contradictions and power structures ignored. It is not surprising that the World Health Organization (1989a) reports that in some nations there is confusion about the meaning of Primary Health Care.

Health and Development

It is in the methodology of Primary Health Care where the contextual and historical pieces of the recommendations have been omitted. The principles guiding health care strategies have been extracted from health care models in countries where the health status of populations has shown significant improvement. What is never acknowledged is that the most impressive gains have been in countries that have undergone a transition to socialism (Ertler, Schmidl, Treytl & Wintersberger, 1987; Waitzkin, 1989), although specific projects in disadvantaged areas of capitalist countries have also been effective using the community development approach to health care (Tollman, 1991). Navarro (1986) argues that it is "class relations and exploitation that are at the root of underdevelopment, poverty and the disease of the majority of the world's population" (p. 219) and that health inequities, particularly in Third World countries, cannot be adequately addressed under capitalist relations of production. As research linking income, primary education and female literacy to improvements in health suggests that these factors are important preconditions for achievement of the latter (Basch, 1990; Cumper, 1983; Grosse & Harkavy, 1980; World Health Organization, 1986), then the salient question may be: Under what conditions is equitable access to education and income promoted? Perhaps health and development research has been constructed on a "spurious" view of reality. Intervening variables have been confused with independent variables. Appearances have been accepted as reality. Regression models have been incompletely specified and findings have been misleading. It is possible, indeed probable as Navarro argues, that the rules (methodology) of Primary Health Care are politically determined. If so, the important question becomes: Under what conditions is a Primary Health Care approach to health likely to be effective?

Early research on the links between health and development appears to have been guided by the Modernization Theory paradigm of development with a focus on Human Capital Theory (Schultz, 1977; World Health Organization, 1988c). The health of populations was perceived as a condition of economic development with investment in the education of health professionals perceived as wise use of scarce resources. Health strategies were approached from an epidemiological perspective and outcomes evaluated in terms of cost-benefit ratios (Lee & Mills; 1983; Prescott & Warford, 1983; Sorkin, 1976; Wheeler, 1983).

More recently, with growing empirical data regarding women's roles in health and development both as producers and reproducers, attention has shifted to the plight of women in developing countries and to the pathways by which women influence the health status of populations (Agarwal, 1989; Browner, 1989; Cleland & Van Ginnekin, 1988; MacCormack, 1989; Raikes, 1989; van Wijk-Sijbesma, 1987). Also ignored in much of the research literature, but of great importance, is the issue of the questionable reliability of health statistics from many developing countries (Basch, 1990; Hayes, Taylor, Bayne & Poland, 1990; Timaeus, Harpham, Price & Gilson, 1988). Unreliable measurements lead to invalid findings. In addition, most quantitative research has been cross-sectional and synchronic, aggregate data have been analyzed. Such analyses incorporate a systematic neglect of historical and contextual influences (Cumper, 1983). The danger of drawing conclusions from aggregate data is that findings can obscure as much as they reveal, a point raised in the sociology of development literature (Brewer, 1980; Hoogvelt, 1978).

There is a growing body of literature on the political economy of health which is less atheoretical, acontextual and ahistorical. New insights, often politically sensitive, are emerging. There is recognition that, as in education, health decisions are not neutral. Political choices are made and inequitable social relations are reproduced. This body of research is closer to the Dependency Theory paradigm of development and has yet to receive recognition in the international arena of aid. There seems to be a gap between the rhetoric of equity and the will to implement social changes which remove structural barriers to equal access to resources and opportunities. In more recent literature, however, references to the influences of colonialism, imperialism and ethnocentrism in structures of health care systems have become more common (Bannerji, 1990; Hezekiah, 1989; Higginbotham & Connor, 1989; Morgan, 1990; Navarro, 1986; Whiteford, 1990). Nevertheless the political repercussions of health care strategies linked to empowerment of the disadvantaged has led many nations to shift:

(i) from the original concept of comprehensive Primary Health Care, with its emphasis on basic needs, self-reliance and self-determination, to

(ii) selective Primary Health Care which focuses on targeting specific diseases for control or eradication. This mode of health care provision takes the form of a service planned and imposed by forces outside the community.
It must be stated, however, that the World Health Organization does not support the shift to selective Primary Health Care (World Health Organization, 1989a).

Empirical research regarding the political economy of health is demonstrating the class nature of inequities in health care (Andersson & Marks, 1989; Decosas, 1990; Deppe, 1989; Ityavyar, 1988; Laurell, 1989; Manga, 1988; Zaidi, 1988). "Primary health care may indeed be 'revolutionary' in its approach - at least on paper - but too many vested interests will prevent it from being revolutionary in practice" (Zaidi, 1988, p. 126).

Towards a Conceptualization of Power

It seems then that what is needed is the infusion of a theory of power to explain developments in Primary Health Care. The literature on organizational change provides rich insights pertaining to the importance of power in the process of social change which this study is investigating.

While in his book Power in Organizations Pfeffer (1981) illustrates the political nature of power by presenting findings from the rapidly accumulating body of empirical research, no real theoretical model of power emerges from his explorations. More satisfying is Clegg's highly theoretical and often very abstract exploration into the many ways power has been conceptualized (Clegg, 1979; Clegg, 1989; Clegg & Dunkerley, 1980). Clegg (1989) begins his discussion of power by contrasting Hobbes' central concept of "sovereignty" with Machiavelli's emphasis on "strategy".

> In Hobbes power is carefully defined and stipulated within a framework in which it is a key term for legislating political community and securing moral order....For Machiavelli power is conceived as pure expediency and strategy rather than as pure instrumentality. (p. 31)

He suggests that Hobbes' conceptualization has dominated modern theories of power:

> In pluralist theory, this has been the sovereign subjects of the people, arranged in interest groups. For elitist theorists, neither all people nor all interest groups are equally instrumental: sovereignty is displayed through the capture and relatively stable deployment of key resources as instruments for the rule of elite groups - those who control the commanding heights of the economy, polity and society. For structuralist or class hegemonic theorists, political community is simply translated into ideological reproduction, class hegemony or false consciousness - a false moral order for which sovereignty resides in the ruling class, ruling structures and ruling meaning. (p. 35)

Power is both a resource and an achievement with sovereignty implying domination.

In the 1950s Dahl suggested that "power is a relation between actors who 'may be individuals, groups, roles, offices, governments, nation-states or other human aggregates'" (Clegg, 1989, p. 51). In his conceptualization, A has power over B. A will have resources (i.e. love, fear or money) which allow this exertion of power over B. The power of A over B, however, will be limited in scope in that A's power over B will not encompass all facets of B's life. Therefore, power is distributed as "different actors (people, in fact) prevail over different issues, producing a 'pluralist' rather than an 'elitist' distribution of power"

(Clegg, 1989, p. 53). Resources are revealed through their effects and a "domain of power" may be estimated by the number of Bs over whom A has power. What are missing in Dahl's theorizing are a "sense of contextual temporality" (Clegg, 1989, p. 54) and a consideration of "intentionality" (p. 66).

In the 1960s Bachrach and Baratz extended Dahl's work by adding the concepts of "non-decision-making" and "important" versus "unimportant" issues (Clegg, 1989, p. 76). With non-decision-making, demands articulated by the less powerful may remain unheard or bogged down in bureaucratic structures with no decision being reached. Issues which the less powerful are likely to oppose may never be raised if controversy is anticipated by the more powerful. Finally, systematic bias may condition which possibilities are even envisioned. Thus history has been constructed as "his" "story". Bias may be mobilized to inhibit changes proposed by the less powerful. An important issue will challenge "dominant values, political myths, rituals and institutions: in short, the mobilization of bias" (Clegg, 1989, p. 76).

In the 1970s Lukes offered a radical and humanist interpretation of power in which he theorized and evaluated behaviour "by reference to a model of what people would do if they knew what their real interests were" (Clegg, 1989, p. 92). Thus the latent (as opposed to overt or covert) dimensions of power were hypothesized. There is a focus on the conditions under which "autonomy might be said to prevail" (p.93). In 1981 Benton identified a "paradox of emancipation" as being at the core of Lukes' view of power (p. 95). Focus is on agency with an emphasis on choice and responsibility. Voluntarism is synthesized with the concept of structural constraint. Clegg critiques Luke's position with:

> It may be adduced that Lukes' (1974) three-

> dimensional view of power does not succeed in delimiting a space in which a privileged insight into power can be developed. 'Real' interests have not been successfully fixed. Moral relativism has not been avoided. Agency and structure are not dialectically synthesized. Agency remains predominant and structure has been marginalized. (1989, p. 103)

There is ambiguity in defining where structural determination intersects with personal power and responsibility.

Giddens, beginning in the late 1970s, has "proposed that the agency-structure terms of debate should be reconceptualized as a unity rather than as an opposition of terms" (Clegg, 1989, p. 129). Gidden's work builds on that of Parsons and emphasizes "symbolic legitimacy". Values are introduced into the conceptualization of power. Socialization into a normative context becomes important. "Power, rather than being a conflictual mechanism which is opposed to social order, is both enabled by and constrained within that social order because of its normative basis" (Clegg, 1989, p. 132). Power can be facilitative or enabling when viewed from this perspective. The hierarchical element in power relations is missing in Parson's work but is reintroduced by Giddens who defines power as the "capacity to achieve outcomes" where "power should not be regarded as an obstacle to freedom or emancipation but is their very medium, although he notes that it would be very foolish, of course, to ignore its constraining properties" (Clegg, 1989, p. 138). An underlying code guides observable power relations. Clegg's analysis of Gidden's position concludes that "at the centre of the project, is the illusory freedom of the constituting subject" (1989, p. 147).

At the core of debates regarding post-structuralism is "some conception of there being a significant relation between power and language" (Clegg, 1989, p. 151). Identity is perceived as in process, contingent, provisional and achieved. "Knowledge which fixes the normal is evidently going to be knowledge which has a close relationship with power" (Clegg, 1989, p. 152). The work of Foucault is closely identified with post-structuralist thought:

> Central to Foucault's conception of power is its shifting, inherently unstable expression in networks and alliances. Rather than the monolithic view of power as the 'third dimension' incorporating subjectivities, the focus is much closer to Machiavelli's strategic concerns or Gramsci's notion of hegemony as a 'war of manoeuvre', in which points of resistence and fissure are at the forefront....Power has been conceptualized as being mostly absent except when exercised. It is exercised only intermittently in discrete episodes....Foucault seeks to show how 'relations of agency' and 'structure' have been constituted discursively, how agency is denied to some and given to others, how structures could be said to have determined some things and not others. The focus is upon how certain forms of representation are constituted rather than upon the 'truth' or 'falsity' of the representations themselves. (Clegg, 1989, pp. 154-55, 156, 158)

Foucault's work is contextual and historical. The work of Laclau and Mouffe suggests to Clegg (1989) that: "Interests, as reasons for action, are not necessarily fixed by the subject: there may be discursively available reasons for action other than those that a given subject articulates in a discourse" (p. 181).

The contradictions inherent in all social interactions and the fluidity of power relations in specific contexts are themes that emerge from Clegg's own theoretical work. What is appealing about it is Clegg's recognition of the agency/structure debate (1989) as resting on a false dichotomy and the need to develop conceptual frameworks which incorporate assessment of both. As Laslett (1990) asserts: "the debates that have emphasized either social structure or human agency now need to focus on their intersection, an intersection in which real live women and men, individually and collectively, struggle to shape their worlds as they are also being shaped by them" (p. 141).

In Clegg's "circuits of power" framework (1989), power is conceived as multidimensional, dialectical and relational since power in isolation does not exist. As a multidimensional construct power has several facets. Hierarchical relationships and expertise are only two of the facets. Gender, age, ethnicity, class, occupation and other socially constructed characteristics may influence power relations.

Power is paradoxical as delegation of power may empower the recipient and change the nature of the relationship between individuals in an organization. There is always resistance to the exertion of power by persons with vested interests in the outcome who feel that their concerns are not being addressed or that their needs are not being met. Periods of transition inevitably include alterations in the configurations of power within a society. That social change should be conceptualized as a multi-level process is congruent with other recent literature (Meyerson & Martin, 1987; Pettigrew, 1987; Van der Geest, Speckman & Streefland, 1990).

The concept of empowerment is integral to an understanding of the contradictions within the concept of Primary Health Care. Self-determination and self-reliance are perceived as the goals of community participation. Empowerment of communities and individuals appears to be a central value of the process of developing a system based on Primary Health Care. Empowerment, however, may be conceived in two distinct ways. It is a relational construct and thus related to the legitimation process. It is also a motivational construct and thus related to autonomy and perceptions of personal efficacy (Conger & Kanungo, 1988). Thus structural features within a society such as legal rights or affirmative action programs relate to the legitimation process and may permit empowerment by removing external barriers while strategies facilitating increases in confidence and self-esteem relate to feelings of personal efficacy and may remove internal (psychological) barriers to effective action.

Just as power relations within communities and between communities and regional or national governments may shift, so may power relations among health professionals and between health professionals and the communities or social structures which they serve. The transition to a new model of health care may trigger or reflect changes within the societal social structure and, taken to the logical conclusion, reflect or trigger changes in global configurations of power.

Power and the Health Professions

Who are the players in Primary Health Care? There is no simple answer. There are individuals and communities who are recipients of services and whose input into the services being offered should be solicited. There are the providers of health and related services who will in many situations include traditional healers and midwives, health auxiliaries and health professionals. There are local, regional and national elites and/or government officials (bureaucrats and politicians). There are suppliers of equipment and drugs. Finally, there is the international community whose influence should not be underestimated. Aid and trade policies influence national decisions regarding the distribution of resources. The World Health Organization is highly influential in conditioning health systems planning and implementation in poor countries. Professional organizations, such as the International Council of Nurses, influence the roles and educational preparation of their members. Professional experts provide consultations which guide policy formation, funding and service delivery.

Producers of supplies control costs which then feed back into funding and resource allocation decisions.

It can be seen that there are a myriad of relationships in which power structures may be operative and may determine the available options and the decisions taken. Some of the players will have contradictory motives and agendas. Some will be well-meaning but naive. Some will be effective in achieving goals. There is little doubt that there will be conflict and power struggles in the period of transition. With change, however, comes ambiguity and often the likelihood of previously entrenched institutional structures crumbling and being replaced. Recognized "expertise" may be a source of much influence at such times (Brint, 1990) and it is crucial that the acknowledged "experts" have the knowledge, skills and attitudes required to guide the change process.

Examination of recent nursing literature reinforces the notion that nursing leaders have a sense that "a window of opportunity" (Welch, 1987, p.282) is available, both in developed and less developed nations, in which "nurses with the needed educational base are prepared to make dramatic use of the forces of ethical, economic and political change to influence the future" (Welch, 1987, p. 282). While much of this literature advocating nursing involvement in the political process has been generated in the more developed countries, particularly the United States (Aroskar, 1987; Aydelotte, 1987; Christensen, 1990; Davis, 1988; Felton, 1987; Goertzen, 1987; Holleran, 1985; McBride, 1987; Milio, 1989; Moccia, 1988; Moore, 1990; Styles, 1987), nurses in less developed countries and nurses with an interest in development issues have responded favourably regarding increased nursing autonomy under Primary Health Care models of health service delivery (Das, 1986; Davis & Dietrick, 1987; de Monterrossa, Lange & Chompre, 1990a; de Monterrossa, Lange & Chompre, 1990b; de Orjuela, 1989;

Edwards & Tomkins, 1988; Garfield, 1988; Hickman & Gobble, 1987; Hrycak, 1986; Keen, 1989; Mehra, 1989; Mule, 1986; Ngcongo & Stark, 1990; Nunez, 1985; Onyejiaku, Holzemer, Morrow, Olabode, Rogers, 1990; Posey, 1987; Spear, Oddi, Vor der Bruegge, 1990; Swanson, 1988; Um, McElmurry & Poslusny, 1989; WHO Study Group, 1987; World Health Organization, 1982). Issues confronting nursing involvement in Primary Health Care are reported from Nepal, Papua New Guinea, the Caribbean region, Pakistan, Nigeria, Latin America, Columbia, Nicaragua, Mexico, Jamaica, India, Kenya, Botswana, Korea and Cuba. What emerges is the positive impact of nursing involvement in some contexts and the difficulty of facilitating nursing involvement in other contexts. Without research into forces affecting nursing contributions in varying contexts any discussion of reasons for the differences is speculative.

There are a variety of approaches to the organization of a primary health care system and thus to the expectations placed on various health personnel. The nursing responsibilities differ in varying systems. Nurses may or may not be involved in independent roles in curative care. They may teach and supervise village level health personnel, another category of health worker may be created to fill that role or physicians may assume the responsibility. Thus different models of Primary Health Care incorporate varying levels of health personnel in different ways.

Nursing as a profession is at different points of development in different societies (Maglacas, 1988; 1989) and in different areas within a society. Thus the power and credibility of nursing personnel differ between and within societies. In a Marxist analysis of the history and meaning of professionalism, Larson (1977) examines "the visible characteristics of the professional phenomenon - professional association, cognitive base, institutionalized training, licensing, work autonomy, colleague "control", code of ethics " (p. 208) from two perspectives: "first, as structural elements of the general form of the professional project, and second, as specific resource elements, whose variable import is defined by different historical matrices" (p. 208). Larson argues that creation of professional monopolies increases the resource base of workers defined as professionals and secures their place in the marketplace under capitalist relations of production. Professionals, in contrast, defend their position in society with claims of protecting the public by ensuring minimal standards of conduct. Medicine, in Larson's analysis, has been the most successful professional group in monopolizing and defending a niche in capitalist society. Similar critiques have been made by others (Esland, 1980; Johnson, 1972). Reference has been made to the growth of professionalism contributing to an ethos of "meritocracy" in work relations to replace the ethos of "patronage" based on class and kinship which still is evident in many less developed counties (Johnson, 1972).

That physicians are perceived as powerful has received confirmation in the literature (Duran-Arena & Kennedy, 1991; Pappas, 1990). That physicians often restrict nursing power, autonomy and authority is known (Katzman, 1989; Shoham-Yakubovich, Carmel, Zwanger & Zaltcman, 1989). In a study of physicians and nurses across 30 cultures, "nurses were viewed as positive, active, and kind, but not associated with power, independence, and knowledge" (Champion, Austin & Tzeng, 1987, p. 47). The physician was viewed as "good, powerful and active, and was strongly associated with power, independence, and knowledge" (p. 47). Licensure often facilitates medical control over other health professionals (Lovell, 1980; Simpson, 1985) and can become a powerful force restricting the full use of nurses in autonomous roles. Manipulation of language facilitates professional control over patients (Connors, 1980; Kuipers, 1989).

What is interesting about the Primary Health Care concept is the focus on the participation and empowerment of communities and on maximal utilization of scarce resources. Integral to it, there appears to be an attempt to demystify the cognitive base of the health professionals and to broaden the base of autonomous practice. Teamwork is valued over hierarchy. Power is to be shared. Physicians have much to lose. Nurses may have much to gain. The concepts of deprofessionalization and proletarianization have been suggested as mechanisms by which professional control may be eroding (Freidson, 1985), but there is no consensus that the power exerted by professionals with claims to superior knowledge is waning. Are deprofessionalization and proletarianization implied in Primary Health Care? Human resource development for Primary Health Care requires attention to more than devising programs for categories of health workers and posting them to rural areas. Support systems must be developed (Simmonds, 1989) and egalitarian attitudes fostered.

International Influences Involving the Nursing Profession

There is a wide interest in international nursing and in a recent survey of American nurse consultants it was found that 58 percent of consultations were to less developed countries (Andrews, 1985). Consultation to less developed countries was usually related to nursing education (Andrews, 1986) and there is concern that nurses engaged in international consultation are inadequately prepared. There is an assumption that nurses from industrialized countries have much to offer nurses in the less industrialized societies. Recently concerns have been raised about "a rapidly forming American nursing imperialism" (Holleran, 1988) which may be a reflection of the estimation that the United States, with 5 percent of the world's population, is home to 25 percent of the world's nurses (Andrews & Fargotstein, 1986).

Primary Health Care has been suggested as a movement with the potential for uniting nurses across international boundaries and thus promoting the empowerment of nurses in all nations (Ulin, 1989). The International Council of Nurses (ICN), founded in 1899 to foster the "development and enhancement of strong national professional associations capable of providing the nursing component in national health-care systems" and to promote "favourable conditions of life and work for its members" (Splane & Splane, 1991, p. 355), in 1985 affirmed global health through Primary Health Care and attention to the socioeconomic interests of nurses to be their highest priorities worldwide.

Anecdotal accounts of international nursing experiences (Malone, 1990; McDowell, 1986) are common in the nursing literature. There has been a call to develop international nursing research which is interconnected in terms of questions asked but which considers diverse perspectives so that a unified body of knowledge amenable to comparative analysis can be assembled (Bergman, 1986; Clay, 1988; DeSantis, 1988; Meleis, 1989) and disseminated (Chibuye, 1989). Nurses are ready and willing to enter the international arena but their influence often revolves around the attempt to foster the profession of nursing worldwide rather than the health of populations (Maglacas, 1986). Most nurses would argue that the two goals converge. It is this assumption that must be examined.

There is much awareness that power in nursing is a gender issue as nursing is a sex-segregated profession (Greenleaf, 1980) and "worldwide, approximately 90% of nurses are women" (Morrow, 1988, p. 22). Nursing knowledge has been devalued as "ascientific" partly because the majority of nurses are women and, in a patriarchal society, men have had the power to control what is accepted as legitimate knowledge (Ashley, 1980; Hagell, 1989; Hughes, 1980; MacPherson, 1983; Sheehan, 1990). It has been suggested that nurses could benefit from tapping into the resources of women's groups (Herzog, 1985). Nursing's strength in becoming the key health professional in Primary Health Care may derive from the reality that nursing is primarily a female occupation (Dier, 1988). Not only do women in traditional societies prefer to seek assistance from female caregivers (Dier, 1988; MacCormack, 1989), there is also evidence that female nurses spend more time in health promotion activities than do male health extension officers, even when occupying identical positions. The male health workers were more likely to pay exclusive attention to curative and administrative activities (Thomason & Kolehmainen-Aitken, 1991).

Increased interest in the role of women in development and in women as providers and recipients of health care (World Health Organization 1983a), combined with acknowledgement that physicians may lack the health promotion skills needed for Primary Health Care and may resist change in the direction of Primary Health Care (World Health Organization, 1988b), may create a situation of fluidity in power configurations which will enable nurses to position themselves in a position of strength within health care systems in specific contexts. Paradoxically, this opportunity may depend on the status of women in a specific society while simultaneously creating an environment for increased female participation in the decision-making structure. International pressure for participation of women is likely to increase and nurses appear to be cognizant of the potentialities imbedded in current international thought.

Reflections on the Literature

The transition to a Primary Health Care approach to improving the health status of populations mandates a change in configurations of power both within the health care system and within society. Resources need to be redistributed. Hierarchical relationships within the health care system must be flattened. Community participation must be encouraged and the social dimensions of health must be recognized. Space exists for disadvantaged groups to act. Nurses may occupy a unique position at this time both because of their knowledge and because they are members of a gendered occupation, primarily female, at a time when both the status of women and the centrality of women in the links between health and development are of international concern. As Splane and Splane (1991) suggest, a successful transition to a successful model of Primary Health Care requires attitudinal changes, educational changes and political decisions which "extend beyond the health-care system as it is usually defined" (p. 364).

While this study addresses the issue of forces shaping nursing contributions to Primary Health Care in Nepal, it is hoped that the knowledge generated will contribute to answering the more important question as to under which conditions are nurses able to contribute most effectively to raising the health status of populations. The purpose of the literature review for this case study is captured by Yin's statement: "Budding investigators think that the purpose of a literature review is to determine the **answers** about what is known on a topic; in contrast, experienced investigators review previous research to develop sharper and more insightful **questions** about the topic" (1989, p. 21).

CHAPTER 3: THE NEPALESE CONTEXT

Because Nepal is a nation undergoing tremendous change, information becomes dated fairly quickly. Thus this discussion of the Nepalese context incorporates information collected prior to data collection in Nepal, information from documentary sources accessed in Nepal and information from recently published materials. As previously discussed, the framework used to assess context for the purposes of this review of the literature includes the areas of natural indicators (geography, ecology, epidemiology, demography); technological and economic development (communication, transportation, electricity or equivalent energy source, water supply, sanitation, economic productivity indicators); historical and sociocultural factors (lifestyles, value systems, traditions in health care and health practices, class and gender issues, religion); relations of production; ideological superstructure (political system, educational system, health care system); and position regarding national independence as opposed to colonial or neocolonial dependence or interdependence.

Natural Indicators

A small land-locked country, Nepal lies in the central Himalayas. Approximately 800 kilometres from east to west and ranging from 90 to 230 kilometres from north to south (Apte, 1990; Wheeler & Everist, 1990), it had a reported population of 18,684,000 in 1988 (World Health Organization, 1989a). There are four distinct geographical areas; flat plains in the south (bordering on India), central hills, midland valleys (home to much of the population) and high Himalayas in the north (bordering on the Tibetan part of China) (Wheeler & Everist, 1990). The Terai (southern plains) was jungle until the 1970s but is now heavily populated and considered the rice bowl of Nepal (Apte, 1990). Expansion of health care and control of malaria have contributed to population growth in this area. Three river systems, flowing from north to south, are impassable during much of the year because of monsoon rains or melting snow. In 1990, 92 percent of the population was living in rural areas where access often requires hours of walking from the nearest road (The World Bank, 1991). For administrative purposes, Nepal has been partitioned into 5 development regions, 14 zones and 75 districts (HMG/WHO Management Group, 1987). Natural indicator statistics for Nepal are summarized in Table 1.

Climate in Nepal depends on two factors: altitude and season. The Terai, a fertile band of jungle, is only 100 metres above sea level whereas Mount Everist, the highest peak, reaches an altitude of 8,848 metres (Wheeler & Everist, 1990). The dry season extends from October to May and the wet season from June to September. Kathmandu, the national capital, is located in the midland valleys and the temperature can range from 30 degrees centigrade in the summer to near freezing at night in the winter (Wheeler & Everist, 1990).

Only 12 percent of the landmass of Nepal is arable, firewood is becoming scarce and there are few natural resources (Justice, 1986). Environmental issues are of major concern. The highest deforestation rate in Asia is in Nepal (3.9%) and "over the past thirty years, Himalayan watershed forests have declined by 40 percent" (Dankelman & Davidson, 1988, p. 45). Environmental degradation may be reaching crisis levels as rural people, in order to satisfy needs for food and fuel, "are stripping steep and unstable slopes for firewood and fodder, and clearing and overgrazing the pastures. Much fertile soil is being lost through erosion and landslides. If present rates continue, Nepal's forests

Table 1

Natural Indicator Statistics for Nepal (including some comparisons with Canada)

NEPAL		
Population in 1988	18,684,000 (WHO, 1989a)	
Rural Population in 1990	92% (The World Bank, 1991)	
Arable Landmass	12% (Justice, 1986)	
Deforestation Rate	3.9% per annum (Dankleman & Davidson, 1988)	
People Living in Poverty	7 to 8 million (The World Bank, 1991)	
Population Growth	2.7% per annum (The World Bank, 1991)	
Adult Literacy Rates	MALE	FEMALE
1952/54	9.1%	0.7%
1961	16.3%	1.8%
1971	24.7%	3.7%
1981	34.9%	11.5%
1988*	51.8%	18.0%
(HMG/WHO Management Group, 1987)	*(WHO, 1989a)	

COMPARISONS	NEPAL	CANADA
Age Structure (1985)		
0-14 years	42.3%	21.5%
15-64 years	54.7%	68.1%
65+ years	3.0%	10.4%
(WHO, 1989b)		
Vital Statistics per 1000 population (1985-90)		
Live Births	39.6	14.4
Deaths	14.8	7.4
Natural Increase	24.7	6.6
(WHO, 1989b)		
Infant Mortality Rate (IMR) per 1000 population (1988)	108 (WHO, 1989a)	
IMR (1986-87)	130.3	7.6
Life Expectancy at Birth	50.3	76.6
Fertility Rate/Woman	6.0	1.7
(WHO, 1992)		

will disappear within the next fifteen years" (Dankelman & Davidson, 1988, p. 60).

A joint study by The World Bank and The United Nations Development Programme revealed that: "By the most conservative definition, between 7 and 8 million of Nepal's population of 19 million live in absolute poverty, defined as having incomes below the level required to support a minimum daily calorie intake (about US$100 p.a. per capita)" (The World Bank, 1991, p. xi). Most of the poor are rural subsistence farmers, although the increasing population and decreasing ability of farmers to meet basic needs from agricultural production are influencing an accelerating rural to urban migration. Prospects for gainful employment in urban areas are grim for most migrants. The report continues with:

> Population growth of 2.7% per annum has eroded the limited gains that have been made in GDP and agricultural output. The population has doubled since 1960, and is projected to double again over the next 25 years. Furthermore, the demographic profile is such that within ten years the labour force will be growing at about 0.4 million persons per year - twice the average rate experienced during the 1980's. The major challenge in avoiding a deterioration in the poverty situation will be managing the absorption of this massive labour force growth. However, in the absence of an effective program to slow population growth, all other poverty alleviation measures will be meaningless. (p. xi)

It is estimated that: "Even under the most optimistic assumptions, the formal sector will not absorb more than about 15-20% of the labour force by 2010" (The World Bank, 1991, p. xii). Recommended as priorities are measures to curb population growth, increase agricultural productivity, increase access to rural areas (in the Terai and a few selected hill areas), increase basic education and develop strategies (i.e. improvements in health, nutrition and access to food) to assist the persons likely to live in absolute poverty "for the foreseeable future" (p. xiv). Rapid expansion of the formal health care system was not perceived as a priority.

Poverty in Nepal was attributed to four factors: (i) a limited resource base; (ii) being landlocked between two large and poor countries; (iii) rapid population growth; and (iv) poor economic performance with the Gross Domestic Product (GDP) growth averaging under 3% a year over the past 25 years (The World Bank, 1991). Alternative analyses of poverty and lack of development in Nepal have been suggested. Seddon (1990), from analysis of the "structure of class relations in contemporary Nepal" argues that:

> although social discrimination on the basis of caste, ethnic and gender differences plays a significant part in maintaining social inequality in Nepal, nevertheless the roots of social inequality and therefore of social deprivation, lie within the structure of the agrarian economy, characterized essentially by unequal control over land and other resources and by archaic forms of exploitation. Given the crisis of agriculture, the growing population pressure on cultivatable land and forest resources, and the fundamental inequality of Nepalese society, an increasing proportion of the rural population experience the combined effects of exploitation, oppression, discrimination and political marginalisation. (pp. xxi-xxii)

Land reform is perceived as integral to poverty alleviation strategies whereas the report of The World Bank (1991) suggests that land reform would have little effect. Seddon (1990) suggests that worsening living conditions of the majority of the rural population in Nepal may lead to significant political and social transformation and that pressure from national and international donor agencies and findings of academic research may be significant forces for change. Khadka's analysis (1991) places emphasis on the interplay of politics and development. While agreeing with Seddon's perception and adding sociocultural constraints (religious interpretation of life, belief in destiny as opposed to hard work and hierarchical, social and caste structures), topographical constraints, economic constraints and population issues, Khadka ascribes primacy to political constraints (lack of grassroots political organization, irresponsible government, centralized political and economic powers, inefficient bureaucracy and lack of political priority given to development issues). He concludes: "In a narrow political atmosphere and with a distinct polarisation of population between urban and rural, between powerless and powerful, between vested interest rich and selfless poor, foreign aid cannot work. It only perpetuates these imbalances" (Khadka, 1990, p. 53). Political transformation is required before the real issues underlying poverty in Nepal may be addressed.

Nepal ranks in the lower half of what have been designated as the 40 less developed countries (World Health Organization, 1989a). Demographic and epidemiological statistics reveal variations that appear related to class and geographic location (HMG/WHO Management Group,1987). Like many less developed countries, the age structure in Nepal is skewed in favour of the younger groups and population growth is of major concern. As previously mentioned, the vital statistics reported in Nepal are often disputed as being inaccurate. Thus the IMR reported for Nepal in 1986-87 was 130.3 (compared to 108 in 1988) (World Health Organization, 1992). Both figures could not be accurate. What is not disputed is that mortality and morbidity rates remain high although significant improvements have been seen in some groups. Childhood diseases, mainly communicable, are perceived as the country's greatest health problem (Justice, 1986). While adult literacy rates are very low compared to other Asian countries and the gender disparities are revealing of gender inequities, progress is evident when changes since the 1950s are monitored.

Technological and Economic Development

With a Gross National Product (GNP) of $160 US per capita in 1988, Nepal ranks as one of 20 poorest countries in the world (The World Bank, 1991; World Health Organization, 1989a). "Food availability, measured in calories per capita, is worse only in Bangladesh, Haiti, and a handful of African countries" (The World Bank, 1991, p. 3). The World Bank (1991) does not perceive income distribution in Nepal as markedly out of balance as the bottom 40% of the population has 18% of the income, the middle 50% has 54% of the income and the top 10% has 28% of the income. Income redistribution schemes would probably have little effect on poverty. Increasing landlessness of the poor, however, is an issue (Seddon, 1990). Underemployment affects all sectors of the population and has been estimated to range between 35-45% of available labour days (The World Bank, 1991). Underemployment of the educated, who may be working in positions not demanding their level of education, is increasing as the pool of the educated increases but expansion of opportunities remains slow. Even when employed in suitable work, productivity is low (Bista, 1991).

In 1988 it was estimated that 77% of the urban population and 24% of the rural population had access to a safe water supply and that 54% of the urban population and 1% of the rural population had access to adequate sanitation facilities. Again, these statistics are comparable to those of other least developed countries (World Health Organization, 1989a). About 40% of the poor living in the hills have to fetch water from long distances (The World Bank, 1991). It is still advised that tourists in the country, even in Kathmandu, refrain from drinking the water unless it has been boiled or purified in another manner (Wheeler & Everist, 1990) as drinking water is almost invariably contaminated (The World Bank, 1991). While electricity is available in major centres, it is unusual in the periphery (Wheeler & Everist, 1990) and district hospitals in towns of as many as 10,000 people may lack electricity (Weiner, 1989). Roads connect major centres but about a third of the population lives in hill and mountain areas that are inaccessible by road (The World Bank, 1991).

Relations of Production

Increasing population and shortage of arable land have not yet led to extensive urbanization as people have been able to migrate to rural areas in the Terai. This option will not be available much longer as land is becoming scarce throughout Nepal and the Terai will be saturated within 20 years at current rates of natural increase (The World Bank, 1991). While there has been some growth in GDP over the last 20 years (average of 3.4% per annum), population growth has eroded these gains. In terms of economic performance, growth in the agricultural sector has been slow while manufacturing output increased in the 1980s. Only 6% of GDP and 2% of employment comes from the manufacturing sector. "The changing structure of the economy reflects the early stages of transition out of subsistence agriculture, coupled with rapid growth of the government sector" (The World Bank, 1991, p. 26). Remaining jobs are are primarily in tourism or construction. In recent years, Nepal has gone from a food exporter to a food importer.

Seddon (1990) rejects The World Bank analysis of poverty in Nepal as primarily a problem of population growth as too simplistic. He believes that "the central dynamic is provided by the contradictions associated with the changing structure of relations between classes - relations of production, surplus appropriation and domination, economic and political struggle" (p. xii). The state is not an instrument of the ruling classes as much as "the subject of economic and political struggle .... crucially conditioned by the changing balance of forces in the wider society, and by its own internal cleavages and divisions" (p. xii). Struggles for survival, control and social transformation are occurring simultaneously.

Nepal is a society in transition and, while concluding that Nepal in the 1980s is "essentially 'pre-capitalist', despite the crucial significance of its economic and political relations with the 'outside world' for more than two centuries" (1990, p. xv), Seddon describes three systems of relations of production currently practised:

(i) Peasant Production - The majority of Nepalese are involved in a form of production in which "a formally independent peasantry utilising predominately household labour is involved with other social classes predominately through the sphere of exchange" (p. xiv).

(ii) Semi-feudal Form of Production - A substantial minority of Nepalese are involved in a form of production in which "rural producers are directly subordinated to and exploited by a landowner in a sphere of production through the payment of rent (in labour or kind) or through share cropping" (p. xiv). Dependency and patronage reinforce class relations.

(iii) Capitalist Form of Production - This form is "characterised by the employment of wage labour on a contractual basis and the accumulation of capital in agriculture by the employer" (p. xiv).

The 1981 census revealed that 86% of the labour force was self-employed with 97% of the self-employed being engaged in agriculture (The World Bank, 1991).

Position Regarding National Independence

About 17% of foreign exchange earnings accrue from tourism, 35% from foreign aid and 7% from remittances from Nepalese citizens working outside the country. Smuggling may be a significant additional source of revenue. Foreign aid and borrowing account for at least half the government's revenue (Wheeler & Everist, 1990) while some estimates are as high as 70 to 80%. Although Nepal was never a formal colony, its strategic position between China and India ensures ongoing international interest in its survival as a nation. Poverty has made it dependent on international agencies, institutions and forces. Trade and industry within Nepal are dominated by India (Wheeler & Everist, 1990). Panday (1989) defines Nepal as a "semi-dependency" both because of its economic ties with India and its dependence on foreign aid and asserts that: "This appears to have robbed the government of its autonomy as well as the will to pursue the country's development, administrative or otherwise" (p. 315). The country uses foreign aid for administrative expenses as well as investment and development initiatives. Expatriate experts advise in many areas of the economy and many development projects operate without the input or control of government agencies. By bypassing government agencies, the support needed to modernize institutional structures is neglected in some development strategies. Bureaucrats are denied the opportunity to become familiar with the institutional structures required to enable projects to run efficiently and effectively.

Historical and Sociocultural Factors

Historically, Nepal has been shaped by the intrusion of Tibetan Buddhists from the north and Indian Hindus from the south although the birthplace of Buddha is believed to be in Nepal and Buddhist belief may predate Tibetan influence. Politically, of modern-day importance is the juxtaposition of the Shah dynasty, including the current royal family, with the Ranas, a family of hereditary prime ministers who administered the country from 1846 to 1950 (Chauhan, 1989; Khadka, 1991; Wheeler & Everist, 1990). The country reverted to a form of royal administration in 1950. The Rana administration was a time of isolation and stagnation whose departure "required the support of a public administration system that did not exist in the country beyond the essentials of the law and order maintenance function" (Panday, 1989, p. 315). Nepal, in many respects, did not enter the modern world until 1950 and, since 1951, socio-economic development has been the principal goal of the state.

Nepali is the national language of Nepal but more than 35 languages are spoken by the approximately 75 ethnic groups in the country (Justice, 1986). Nepali is the mother tongue of 58.4% of the population. Mathili is spoken by 11.1% and Bhojpuri by 7.6%. No other of the languages spoken in Nepal is mother tongue to more than 5.1% of the population (HMG/WHO Management Group, 1987). English is widely spoken by the educated elite.

Officially, Nepal is a Hindu kingdom but there are substantial Buddhist and Muslim minorities in some regions (Justice, 1986). There are also small groups of Christians (Wheeler & Everist, 1990). The estimated proportions are Hindu (89.5%), Buddhist (5.3%), Islam (2.7%), Jain (0.1%) and Christian (< 0.1%) (HMG/WHO Management group, 1987). The Hinduism of Nepal blends Hindu and Buddhist traditions.

Caste is thought to be an issue in daily practices, many of which relate to food or water exchange. Traditionally, high caste Hindus would not receive food or water from anyone of the untouchable caste and would only eat rice and lentils prepared by someone of the same or higher caste (Bennett, 1983). Other foods could be received from persons of lower caste but not from untouchables. Caste, gender and age define relations of power and food is often used to "mark hierarchical divisions between individuals and groups" (Stone, 1983, p. 971).

Diet and dietary practices are perceived as closely related to health in Nepal (Reissland & Burghart, 1988; Stone, 1983) both as sources of ill health and as treatment of disease. Even where Western medicine is available, traditional cures are sought in lieu of, or as an adjunct to, biomedical science (Adams, 1988; Durkin, 1988; Mercer, 1983; Parker, 1988). Faith healing is a predominant form of traditional health care, with approximately 500,000 practitioners involved at the village level. Astrology and attention to the spirit world are tools used to assess and treat the afflicted person (Parker, 1988). Ayurvedic medicine, homeopathy and Tibetan medicine are also practised alongside the Western biomedical model (Streefland, 1985).

The sociocultural context of Nepal cannot be understood without analysis of issues of class, caste and gender. In the introduction to the fifth edition of People of Nepal (1987), Bista, a Nepalese anthropologist who has devoted a career to study of the many ethnic groups in Nepal, comments on the complexity of ethnographical research in Nepal and on the incomplete nature of current knowledge. In his controversial recent book Fatalism and Development: Nepal's Struggle for Modernization (1991), Bista interprets Nepal's lack of development from social and cultural perspectives. He is strong in his criticism of scholars, primarily Westerners, who study Nepali society using a theoretical framework based either on a theory of social stratification predicated on the Indian caste system or on a development theory which views Nepal as a peripheral nation dominated by western centres of capitalism and imperialism. "Nepal is not like India. This is a critical point. And an overemphasis on the structural qualities of caste often simply obscures more critical issues concerning value systems" (Bista, 1991, p. 8). He perceives his book as an assertion that "Nepal's problems follow from certain attempts at the Indianization of its culture" (p. 8). He would agree with Seddon (1990) that the caste hierarchy is "ultimately subject to the dynamics of class relations and the various forms of economic inequality" (p. 187) but that the caste hierarchy was significant in "creating the social and ideological preconditions for a distinctive form of oppression and discrimination" (Seddon, 1990, p. 187).

Bista's thesis (1991), which was widely discussed by foreign aid advisors and denounced by Nepalis during my time in Nepal, centres on the Hindu religion, particularly the fatalistic attitude promulgated in the belief system, as the main reason for the lack of progress toward modernization in Nepal. Caste principles are not firmly entrenched in the general population but rather have been imposed as a tool by which some high caste Nepalis have legitimized and consolidated their class positions. While caste is not a precise predictor of social class, the two are correlated as there are tendencies for most of the landless peasants to come from the untouchable or artisan castes and for most large landowners, particularly in the Terai, to be Brahmin (the highest caste). Seddon (1990) believes that social divisions which appear to be imbedded in the caste system are better explained "historically in terms of evolving class relations and the role of the state in making land grants to members of the ruling class and to local notables" (p. 188). The royal family are Thakuri and are firmly entwined in the caste system in which the hierarchical structure in order of descending importance is Brahmin (priest caste), Thakuri (royal family), Chhetri (warrior caste) and then followed by the merchant, artisan and untouchable castes. Most of the ethnic groups are perceived as of the same level as the artisan castes. Some Newars, the original inhabitants of the Kathmandu Valley, have carved a place for themselves within the higher caste levels in part because of their industriousness and financial success. They have done this partly by creating a Newari caste system. Power, both economic and political, has historically rested in these groups and, to a lesser extent, in Rajput groups who immigrated to the Terai from India. Until recent years, education was primarily accessible only to these groups. There are, however, people from each of these caste groups living in poverty in Nepal. Certain ethnic groups (Gurungs, Magars, Limbus and Rais) have received preference for recruitment into the British Gurkhas and thus received higher levels of pay than much of the population (with remittances sent home and retirement pensions) and better educational opportunities (Seddon, 1990).

While discrimination on the basis of caste has been illegal in Nepal since 1963 (Bista, 1991), Brahmins and Chhetris dominate in politics and in government bureaucracies. They have thus been able to control and manipulate the information that is reported about Nepal. Bista challenges the social statistics that have been published and questions that 89.5% of Nepalis are Hindu as the government automatically assumes that persons not identifying themselves as another recognized group are Hindu, whereas Bista perceives several of the ethnic groups as shamanistic. There are no reliable statistics of the numbers in each ethnic group in Nepal (Bista, 1991). Many of the ethnic groups have casteless societies.

Underlying the caste system, which is in reality an occupational classification system, is an "ascription of qualities of graduated social pollution, with the most polluted becoming pariahs" (Bista, 1991, p. 36). Activities viewed as polluting, "eating, urination, defecation, copulation, menstruation, birth and death" (Bennett, 1983), are significant when examining how nurses are perceived in Nepalese society. While some ethnic groups, such as the most prosperous Magars and Tamangs, were accepted into Chhetri status during the early changes of the introduction of the caste system into Nepal (Bista, 1987), most ethnic groups received no advantage from ascribing to caste beliefs and Bista (1991) perceives little evidence of caste beliefs being entrenched in these groups. He also perceives the value systems of many of the ethnic groups as conducive to development and anticipates that, as these groups take advantage of educational opportunities and become more active in positions of power, development in Nepal will accelerate. Of interest is Bista's belief that oppression of women is not endemic in Nepal but is rather an artifact of Brahmin-Chhetri domination.

In his controversial book Fatalism and Development: Nepal's Struggle for Modernization (1991), Bista argues that values inherent in the Hindu belief system have impeded development. Ascriptive rather than meritocratic ethos guide decisions relating to hiring and promotion of personnel within government service. Competence and hard work are not rewarded and status accrues from reaching a position where all work may be delegated. Higher education, particularly foreign education, is highly valued. Corruption and dependency are fostered.

While the attitudes impeding progress are high caste (Brahmin-Chhetri) in origin, Bista believes that the fluidity in the caste structure in Nepal, which allows the possibility of advancing their caste status to prosperous persons from certain ethnic groups, ensures that high caste values remain dominant amongst the successful. Two customs, "afno mannche" and "chakari", are perceived as key problems. Afno mannche is translated as "one's own people" and is organized around principles of inclusion and exclusion. Bista states:

> Afno mannche has the potential of being constructively used as a natural form of social organization within Nepal, but it can also be readily subverted to negative ends. In particular it encourages problems of inclusion-exclusion, as group members gain particular privileges. Being a part of the outer circle it can impede cooperative action. Difficulties also arise when membership in a desired circle of afno mannche can be purchased only through traded privileges. With afno mannche one finds exclusionary tendencies, factionalism, failures in cooperation, and corruption in various forms leading to malfunctioning of development administration and dissatisfaction at every level. (1991, p. 4)

The practice of chakari, which Bista defines as sycophancy, combines qualities of fatalism and dependency and thus exacerbates the forces impeding development. Bista states:

> The origin of chakari (sycophancy) lies in religious ritual practices of obeisance, which was extended to the governing classes and then to all in certain positions of power. As a social activity, its most common form is in simply being close to or in the presence of the person whose favour is desired. Instead of efficient fulfilment of duties and obligations, persistence in chakari is seen as merit, and with enough merit favours may be granted. It is a passive form of instrumental behaviour whose object is to demonstrate dependency, with the aim of eventually eliciting the favour of the person depended upon. Chakari behaviour is often the lifetime occupation of the adult, though the rewards can be great. By practising chakari over several generations a particular family may even be able to raise its class or caste status. Chakari has to be nourished and requires persistence. The strategy of chakari and the concept of productivity in those who practise it are alien to modern economic thought and systems, and can in no way support genuine development. Chakari is an indication that Nepal not only needs to learn new things in order to

> progress, but must also unlearn old things. Chakari may not be easy to eradicate, but it needs to be purged if economic success is to be a reality in Nepal. (1991, p. 5)

Bista suggests that: "In the present context aid becomes merely something that is due to Nepal and not a resource that is meant to be considered seriously and used productively" (1991, p. 5).

Education is also affected by prevailing attitudes. Bista continues by stating:

> Scholarship in the Sanskritic tradition is associated with privilege and never with labour. Education is traditionally the prerogative of the upper classes: to be educated is a powerful symbol of status. Education is not perceived as a means of acquiring skills that can be used productively to secure economic prosperity but is seen as an end in itself which once achieved signifies higher status, and in association with which the privileges of status are expected automatically. As educational opportunities increase and become accessible to lower classes, the educated lower class use education as a means to rapid social advancement, but the traditional route is used. Acquisition of education is the perceived acquisition of status and there is an expectation that it will be immediately associated with privilege. To become educated is to be effectively removed from the workforce. Within such an atmosphere a genuinely productive workforce can never be developed and professional activities must continue to be performed by the untrained. Those that do have a productive orientation toward education, and have gone ahead to acquire technical and professional skills with the intention of using these to improve their circumstance and those of others around them, are usually not recognized and are not considered as models. (1991, pp. 5-6)

Bista does not perceive the fatalistic hierarchical system, centred mainly in the Kathmandu valley, as indigenous to all ethnic groups in Nepal but he does believe that it is spreading.

As a Nepalese anthropologist, currently a Professor Emeritus at Tribhuvan University, Bista is aware that his thesis is controversial and may not be palatable to the power structure within Nepal. While not qualifying his argument, he does state:

> This book struggles to present the Nepali perception of social process. It is a struggle because Nepal is such a complex cultural conglomeration seeking perpetually to accommodate, if not synthesize, its diverse discrete parts. Nepali society is heteronomous and is in a constant flux. This makes the process of analytic generalization difficult and subject to even more qualification than is normally the case. Nonetheless, I believe my generalizations to be warranted with the caution that the book is centred on the cultural systems of the high caste Hindus. But generalization is the only way with which we can learn anything about the complex society such as that of Nepal. (1991, p. 7)

Bista's thesis is not inconsistent with recent thrusts in the sociology of development theory. Sociocultural, economic, political and international influences are synthesized but primacy is given to the sociocultural milieu. Power structures are not ignored but neither are the actions of individual social actors.

Contrary to Bista's assertion, there is evidence to support the view of systematic discrimination against women in Nepal. Inequity in the literacy rates between males (51.8%) and females (18.0%) (World Health Organization, 1989a) seem significant. The work burden of women, because of their involvement in subsistence agriculture as well as domestic activities, has been estimated to be 25% higher than that of men (The World Bank, 1991). This expectation of more work from females starts early in life and "girls 10 to 14 years old have a work burden about double that of boys in the same age group, and the pattern seems not to be dependent upon the poverty or otherwise of the family" (The World Bank, 1991, p. 21). Unlike most other societies, there are more men than women in Nepal. Life expectancy for women in 1990 was 52.60 years as opposed to 55.38 years for men

(Maskey, 1991). While the high maternal mortality rate (8.5) is a possible factor, it does not explain the higher mortality rate of girls under five years of age (187) as compared to boys (173) (Maskey, 1991). It is hypothesized that, as boys are valued more highly (Singh, 1990), girl children may receive less preventative health care (i. e. immunization), less curative care for childhood illnesses and less food when resources are scarce. A recent study revealed that, for the study population, girl children were not disadvantaged in the quantity and quality of food they received but the pattern of adult women eating last adversely affected the nutrient intake of women (Gittelsohn, 1991). There was no mention of a scarcity of food in the study population.

In a study of Brahmin and Chhetri women in a specific community, Bennett (1983) was struck by the ambiguities of women's role as mediators of the sacred and the profane. In their filiafocal relationships with their birth families, they are symbols of purity with a perceived relationship to the sacred. As such, they are cherished. In their patrifocal relationships with their husband's family, they are connected with the profane and may be abused by their in-laws, particularly until the birth of a son. Chastity must be protected in the unmarried girl and may explain many of the restrictions on female activities. After marriage, they become part of their husband's family and this may explain some of the reluctance of parents to invest in the education of girls. Boys' earnings will contribute to family fortunes while girls' incomes will accrue to their husbands' families. While the value ascribed to women may be different in other ethnic groups (Bista, 1987), the Brahmin-Chhetri values have been assumed to permeate Nepali society and are idealized in a book on Nepalese women by a Nepalese academic (Majupuria, 1989).

A high caste Newari friend characterized the difference between men and women as analogous to the difference between paper money and a coin. A woman is like paper money, which will disintegrate in water. A man is like a coin, which remains intact in water. This woman, who had a high school education and was economically productive, viewed women (herself included) as intrinsically weaker than men. Singh (1990) suggests that a number of Hindu cultural practices are very damaging to the self-esteem of girl children. Males eat first, are breastfed longer and are introduced to solid food later. Girls provide more labour within the family and are expected to contribute to family chores at an earlier age. The birth of a boy is celebrated while that of a girl may be greeted with regrets. Life and death rituals, supported by religious explanations, are centred around males. Penance, self-restraint and self-denial are seen as virtues in women. For example, fasting by a woman is believed to bring good fortune to her family and long life to her husband. Girls learn to be self-effacing and obedient. Singh, who is one of the nurses in Nepal who has an earned doctorate, points out the paradox whereby these traits are primarily inculcated by the mother.

A series of studies on the status of women in Nepal was initiated at the Centre for Economic Development and Administration at Tribhuvan University in Kathmandu in the late 1970s. A statistical profile of Nepalese women was compiled in the first study (Acharya, 1979). Data from 1971 revealed that 49.3% of the population was female and that early marriage and large families were the norm. Life expectancy was lower for women than men, female participation in administrative and political decision-making was marginal and women's contributions to the national economy were ignored in government statistics. Few women were engaged in economic activities outside of agriculture and if they were, the vast majority were employed in unskilled low status jobs. A later study

(Acharya & Bennett, 1981) suggested that rural women generated more income than men (50% as opposed to 44% with children contributing 6%). While women's labour and decision-making contributions exceeded those of men in subsistence agricultural enterprises, access to the outside world of government agencies, politics and the market economy was primarily controlled and understood by men. Reejal (1979) concluded that, while women had not been specifically targeted in national development plans, the main thrust of the plans had benefited women as much as men. He (the authors of the other studies cited are female) concludes:

> Issues relating to sexual differentiation and household authority have their ideological underpinnings in the Western feminist movement. This has not only led to a gross misinterpretation of the role and position of women in Nepalese society but also to a gross misrepresentation of the pattern of relationship between the sexes as visualised by sacred literature of Sanskritic Hinduism. (p. 159)

Of interest was Reejal's observation that the surplus of male labour was leading to the "invasion of traditionally feminine fields" (p. 157), an observation relevant to the nursing profession in Nepal.

Examination of the National Code and documents relating to the legal status of women revealed a juxtaposition of modern and traditional ideologies (Bennett, 1979). The International Women's Year (1975) was significant in Nepal as amendments to the legal code enacted at that time improved the legal status of women. Women, however, have not received equity with men in the laws governing property, inheritance, marriage, divorce and child custody. "These laws were found to be complex and clearly bound to traditional social patterns such as the joint family ideal, patrilineal transmission of landed property, and cultural ideas about women's roles" (p. 87). Discrepancies in legal provisions continue even though the 1951 Nepalese constitution guaranteed "equal rights to every citizen irrespective of caste, creed or sex" (National Development Group High Level Panel, Ministry of Education and Culture, 1990, p. 28). Women have had the franchise since 1948, although other criteria for identifying qualified voters effectively restricted their exercise of the power until 1951 (Thapa, 1985). During part of the Rana rule, up until the late 1940s, it was illegal to teach girls to read and parents who violated this law could be punished (Mitchell, 1977).

Analysis of women's groups in Nepal revealed that groups concerned with political causes and the status of women started as early as 1913 ((Pradhan, 1979). These groups, however, have been dominated by upper class women and it was felt that "most of the programs to date have merely carried out the general policies and ongoing programs designed by His Majesty's government" (Pradhan, 1979, p. 111). They have been isolated from other agencies and failed in achieving meaningful change. For example, "supervisors have been trained for field positions to compensate for the apathy towards women's programs shown by local panchayat officials, yet no salaried posts were created for these supervisors" (Pradhan, 1979, p. 113). While there are no legal barriers to women's participation in positions of power, the role of women in decision-making positions remains limited. In the early 1970s, Mitchell (1977) studied the attitudes of women currently at university and compared them with women leaders who were educated many years earlier. She discovered a generational difference between the groups. The older women valued their education and autonomy whereas the younger women generally perceived themselves as becoming wives and mothers in the future rather than becoming leaders for social reforms affecting women.

Ideological Superstructure

The King has been the constitutional head of state in Nepal since the 1951 Government of Nepal Act. This act envisioned a democratic state but the reality has been far different and the crown retained substantial power. General elections held in 1959 paved the way for a parliamentary system but conflicts with traditional royal powers led to dismissal of the government by the King in 1960. In its place, the panchayat system was introduced (Panday, 1989). Accordingly, "Local panchayats (councils) chose representatives to district panchayats which in turn were represented in a national panchayat. The real power, however, remained with the king who directly chose 16 members of the 35 member national panchayat, and appointed the prime minister and his cabinet. Political parties were banned" (Wheeler & Everist, 1990, pp. 14-15). By 1979 political dissent led the King to agree to a referendum to choose between the current system and a multiparty system. While the concept of a multiparty system was defeated, elections were held in 1981 in which the people elected the legislature for a 5 year term and the legislature elected the prime minister. All candidates ran as independents but were required to belong to one of six designated organizations. The King appointed 20% of the legislature (Wheeler & Everist, 1990).

The appearance of democracy, however, disguised a more dictatorial reality with restriction of freedom of the press, an oppressive military/police apparatus and imprisonment of dissenters and opposition political leaders. The aristocracy, led by the Rana family which has intermarried with the royal family, still wielded significant power. Political protest and agitation against the uni-party Panchayat system in early 1990 forced the King to lift the ban on political parties and an election was called for the spring of 1991 (Wheeler & Everist, 1990). A new constitution, based on principles of basic human rights, adult franchise, a parliamentary system, multiparty democracy, and an independent judiciary, was implemented in 1990 (Thapa, 1992). The king remains as a constitutional monarch. The legislature is composed of the king and two houses of parliament. The performance of the Interim Government which was appointed by the king to run the country from early 1990 to the elections in mid-1991 has been assessed by Thapa (1992) as:

> The Interim Government also left behind the legacy of a disjointed team often working at cross purposes. It attempted to tamper with the bureaucracy but not in a cohesive and systematic way. Except for the retirement of some high-level officials and the appointment of supporters by all parties, especially the ULF supporters, no change in the direction, structure, or objective of the bureaucracy was attempted. In fact, a bureaucracy already crippled with malefic growth and corruption was allowed to degenerate further. An across-the-board salary hike for government workers led to indiscriminate increases in the already burdensome public sector, and strikes by government employees became endemic. Corruption and mismanagement continued as legacies; according to local press reports, the denudation of forests for party and personal gain in the interim period exceeded all previous records. (p. 177)

To give a more balanced picture of the interim period, Thapa (1992) continues with:

> But on the whole, the Interim Government must be credited with achievements of historic proportions. In a period of 13 months, a new constitution was promulgated, general elections were held, and there was a smooth transfer of power to a new government. These achievements were as much the result of efforts by the Interim Government as of the experience and political acumen of Congress Supremo G. M. Singh and Premier Bhattarai, whose leadership was critical to these successes. So while the interim period retained a sluggish continuity in economics and administration, it brought substantial reform and restructuring to political life. (p. 177)

Forty-four political parties were registered for the 1991 elections and 20 parties fielded candidates. In addition, there were 397 independent candidates. Although election violence was predicted, 7.3 million people voted (65.15% of registered voters) and international observers were satisfied with the electoral process. The Nepali Congress Party won with 37.75% of the vote and 110 seats in the 205 seat parliament. Their closest competitor was the United Marxist-Leninist Party with 27.98% of the vote and 69 parliamentary seats. The greatest surprise was the success of the United Marxist-Leninist Party in Kathmandu where they won four of the five seats "disproving the general view that the communist party was primarily rural-based" (Thapa, 1992, p. 179).

The new government has given priority to economic, political and foreign affairs. While the 1990/91 budget of the Interim Government was critiqued as "the basic concern here is that the budget retains its inherent weaknesses in the implementation mechanism of the financial policies" (Sharma, 1990, p. 46), the 1991/92 budget of the Nepali Congress Party was praised for its intent. In reality, however:

> While the budget can be credited with focusing on basic needs of the rural poor in its development expenditures, there simply are not enough resources to manoeuvre for the desired goals. In the end, the budget represents a continuity in that the goals for investment, as well as for resource allocation, must fall within limits set by international lending agencies. (Thapa, 1992, p. 180)

It seems likely that reform and innovation will be welcomed by a newly elected political body, but it is difficult to assess the thrust of future initiatives at this time. Panday suggests that a patronage system of political power has inhibited the formation of a meritocratic professionalised bureaucracy and thus limited development efforts as development, with its emphasis on equity, has been "inconsistent with the prevailing values" (1989, p. 327). While political values have changed, social values are still in transition. People have high expectations of the democratic process and there seems to be a tendency to disassociate the concepts of freedom and responsibility. It is not coincidence that the Civil Service launched a strike for higher salaries shortly after the election. Government activities were blocked for two months and the dispute was referred to a pay commissioner and still was not fully resolved several months later (Thapa, 1992).

The Education System

Although technically part of the ideological superstructure, the education and health care systems are being discussed in separate sections. Education can be viewed as an instrument for social reproduction or for social change. During the Rana regime there was a tendency among the rulers in Nepal "to withhold educational facilities as educated and enlightened people were considered a threat to the political system of the country. It was only after 1951, that educational facilities at various levels were expanded and restrictions relaxed to make them available equally to all the sections of the population" (Vir, 1988, p. 9). Developing the educational system is compatible with the human capital theory of development. For reasons partly related to the topographical features of Nepal, lack of a developed infrastructure and poverty, educational expansion in Nepal has been most successful in urban regions. When the National Education System (NES) was expanded in the 1950s, a pyramidal structure was adopted with Tribhuvan University at the peak followed by a college system for liberal arts and sciences, including professional colleges. High schools had grades IX and X, middle schools had grades VI to VIII and primary schools had grades I to V. Children could be admitted to primary school at age 5 or more. As Vir (1988) states:

> The progress in education during this period (1950-70) may be regarded as quite remarkable due to the liberal policy of late King Tribhuvan and King Mahendra. These rulers recognized the importance of education for economic development, achieving good social order, preserving and transplanting national cultural heritage, fulfilment of general national needs and objectives. Thus, it was the realization that education can bring about desired development and change that inspired the Kings to liberalize educational policy in the larger interests of the people. (p. 38)

Regional inequities, however, have persisted. From 1950 to 1970, almost two-thirds of the graduates from higher education (beyond high school) were students from the Kathmandu Valley while one-sixth of the graduates were from the eastern plains. That left one-sixth of graduates originating from the remainder of Nepal (Vir, 1988). Less than one percent came from mountain areas and only slightly over ten percent from the hills, if the Kathmandu Valley is excepted.

Higher education has been divided into four levels: (i) certificate - to provide low level manpower (the Canadian equivalent to the registered nurse is at this level); (ii) diploma level - to provide middle-level manpower (the post-basic BN for nurses is at this level); (iii) the degree level - to provide high-level manpower (the master's degree is at this level and the first master's student in nursing in Nepal is to be admitted in 1992 - several nurses have master's degrees from outside of Nepal); and (iv) the research level - to provide specialized manpower (currently two Nepalese nurses have doctorates and others are in graduate school). By formal standards, highly placed Nepalese officials are well educated. In a study of students in schools in Tansen and Pokhara in 1974, Vir (1988) found that 88% were Brahmin, Chhetri or high caste Newar while most of the remaining 12% were Thakalis or Gurung (groups often placed in the middle stratum of society). It is from these groups that participants in higher education in the eighties will have been drawn. Planned expansion has been the thrust of educational development in the 1980s and 1990s (Vir, 1988) with focus being placed on participation of rural children (Ashby, 1985; Shrestha, Lamichhane, Thapa, Chitrakar, Useem & Comings, 1986), the poor (The World Bank, 1991) and girls (Education Working Group NGO Committee on UNICEF, 1991; Rai, 1981; Upadhyaya, 1990). Strategies have included free primary school education (extended to grade V in 1992) and financial incentives for girl students (Rajbhandari, 1990).

Of importance to this case study on nurses and Primary Health Care in Nepal are issues related to higher education. Watkins and Regmi (1990) report that English has in the past been the language for university education but that Nepali has replaced it in undergraduate education. Six out of seven nursing campuses in Nepal are under the aegis of the Institute of Medicine at Tribhuvan University. Women's participation in academic life is reflected in the enrolment of Tribhuvan's many campuses. In 1987-88, there were 65,304 male students and 17,117 female students (Watkins & Regmi, 1990). Problems identified in tertiary education are: (i) passive students who expect teachers to present all relevant material, (ii) serious financial constraints in university funding leading to low faculty salaries and few opportunities for promotion or research, and (iii) pass rates as low as 10% but a system which allows students to repeat courses indefinitely. "Recent political disturbances which have resulted in frequent closures of the campuses have exacerbated the problem" (Watkins & Regmi, 1990, p. 460).

Also of importance is the School Leaving Certificate

(SLC) examination which is written after grade X. It must be passed for students to enter the college system (including nursing at the certificate level). It is a national test in which both Nepali and English responses are required. Grading is not standardized and no tests of the examination's reliability and validity have been done (Ministry of Education and Culture with the United States Agency for International Development, 1988). Pass rates are low, particularly in rural areas. Administrative irregularities (i. e. cheating) are common. Schools are evaluated on the percentage of their grade X graduates who pass the SLC examination and this has led to a gatekeeping function of the school examinations at the grade X level (fewer students pass the grade X school examinations than the examinations in lower grades). To write the SLC examination, a grade X pass is required. Nationwide pass rates in the SLC examination between 1980 and 1986 have been: 1980 (29.4%); 1981 (21.4%); 1982 (16.7%); 1983 (20.3%); 1984 (23.8%); 1985 (29.6%); and 1986 (28.9%). There is a government policy (not applied to rural areas) that any school with an SLC examination pass rate less than 16% for three consecutive years will lose its government funding. The pass rate is calculated from the number of students taking the SLC examination and not the number of students enroled in grade X in the school that year. (Ministry of Education and Culture with the United States Agency for International Development, 1988). This pressure to pass the SLC examination has led to a proliferation of private schools for children from families with financial resources and to what appears to be a two-tiered educational system. A child's whole future often hinges on the SLC examination.

The Health Care System

Development of a formal health care system in Nepal is recent and has been hampered by the topographical features of the country as much of the population lives in villages far from motorable roads (Streefland, 1985). Prior to the 1950s, there were no public health programs, fewer than a dozen Nepalese doctors and few hospitals in Nepal (Gubhaju, 1991). The Nepal Medical Association was established in 1950 and the first School of Nursing opened in 1956 (Streefland, 1985). Mission hospitals played an important role in the early development of health services (Streefland, 1985), despite legal prohibition of proselytizing (Bista, 1991). Prior to the initiation of the First Five Year Plan in 1956, there were 34 hospitals (625 hospital beds), 24 allopathic dispensaries and 63 Ayurvedic dispensaries in all of Nepal (Gubhaju, 1991).

Development of the westernized health care system is best traced with reference to the numerous government and WHO documents outlining the aims, successes and failures of the Five Year Plans (Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO Management Group, 1988; His Majesty's Government of Nepal, 1981; His Majesty's Government of Nepal in Cooperation with United Nation's Children's Fund, 1982; HMG/WHO Management Group, 1987; WHO Regional Office for South-East Asia, 1987). In Primary Health Care in Nepal (1987), Mathema utilizes government documents and findings from health research done in Nepal to analyze the current state of health services. Health development from 1956 to 1990 is classified in four stages. During the First, Second and Third Development Plans (1956 to 1970), an epidemiological approach to health care was developed. While curative hospital services were expanded, emphasis was placed on development of public health services. The approach taken was epidemiological as concentration was on single-purpose vertical projects (malaria, tuberculosis, smallpox vaccination and family planning). Health care personnel were educated for one specialty and provided village outreach services. Health posts were established in rural areas for the provision of basic curative services. In the Fourth Plan (1970-75) a change in focus was proposed. The epidemiological focus was replaced by a community health focus and an intent to provide integrated community health services in rural areas. The concept of a village health worker whose role would be primarily in disease prevention and health promotion was introduced. Health posts, administered by health assistants and staffed by assistant nurse midwives and auxiliary health workers, would provide integrated curative and community health activities. A pilot project was launched. The Fifth Plan (1975-80) proposed that the integrated community health program be expanded.

The Sixth Plan (1980-85) was developed after the Alma-Ata declaration suggesting Primary Health Care as the best strategy for achieving Health for All by the Year 2000. Nepal was one of the signatory countries of this declaration. Justice (1986) suggests that it was anticipated that infusing the concept of community participation into the provision of basic health services would transform the existing services into Primary Health Care. Thus during this period the Community Health Leader (CHL) was introduced into the system "as a voluntary health worker to bring health consciousness and to deliver primary health message to the villagers at the local level" (Mathema, 1987). Public participation was sought for implementation of the CHL program. In line with development thrusts of the 1980s, emphasis was placed on programs designed to meet "Basic Minimum Needs" defined as food, fuel, drinking water, basic health services, primary, vocational and adult education and basic transportation (His Majesty' Government of Nepal, 1981). Priority was placed on strategies to increase production and productive employment opportunities, particularly in agriculture. Development of cottage industries, export trade and tourism, as well as conservation of natural resources, development of water resources and full utilization of the existing infrastructure were stressed. In recognition of the inability of the existing economy to absorb the available resources (a contradiction in a resource-poor nation), steps were taken to increase the absorptive capacity. Strategies included:

(i) the Decentralization Act of 1982 designed to decrease the total control of economic decisions from Kathmandu;

(ii) encouraging higher productivity by reform of institutional frameworks guiding promotion, transfer and other rewards;

(iii) strengthening administrative functioning to alleviate gaps between planning and implementation;

(iv) human resource development;

(v) increasing supplies of construction materials so that expansion targets could be met; and

(vi) controlling population growth.

Inequities related to gender, land ownership, and educational opportunities were addressed. Targets were set to include primary school enrolment of 95% by the year 2000 and construction of sanitation facilities at all schools constructed from 1980 (His Majesty's Government of Nepal, 1981). An interesting piece of information from one of my nurse educator co-researchers concerned the sanitation facilities at schools. The construction of latrines was intended partly as a health teaching tool to improve students' knowledge of hygienic practices. A common practice, however, has been to keep the facilities locked as students do not use them properly and they quickly become fouled. A second strategy has been to charge for their use and hire a peon to maintain them. The result has been that latrines at schools are bypassed and the opportunity to promote improved health practices has been lost.

The Seventh Plan (1985-90) reaffirmed the commitment to Primary Health Care and focused on implementation strategies. During this time, 30.2% of the total budget was directed towards social services with the health sector receiving 4.6% (Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO Management Group, 1988). In 1984/5, 68.8% of the national health budget was spent on Primary Health Care activities and 1.15% of the GDP was spent on health (HMG/WHO Management Group, 1987). Of increasing concern were the lack of financial resources and of personnel skilled in financial management. In 1986/7, 53.7% of health expenditures were met by foreign aid allocations (Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO Management Group, 1988). WHO collaboration with health care in Nepal started in 1953, including steadily increasing financial assistance and participation in health projects. International influence in health care planning in Nepal is inevitable given the amount of financial support being accepted.

As previously discussed, the political system in Nepal underwent transformation in the 1990's following protest and agitation over the uni-party Panchayat system. Multiparty democratic elections were held in the spring of 1991 and the Nepali Congress Party was elected. A paper outlining the National Health Policy of His Majesty's Government of Nepal (Ministry of Health, 1991) has been released. The policy affirms the new government's commitment to the Primary Health Care model of health care system organization. Priority is given to the delivery of services in rural areas, with emphasis to be placed on programs which are designed to reduce infant and child mortality rates. Preventive health services will be integrated with promotive health services and curative health services. A referral system will be developed to facilitate access of the rural population to the more sophisticated hospital services as warranted. Intersectoral coordination and community participation will be encouraged. Deficiencies in existing health services were defined as:

(i) lack of village orientation in policies, objectives and strategies leading to an inability to absorb existing resources,

(ii) weaknesses in implementation of plans and programs,

(iii) inadequate supervision, monitoring and evaluation of programs,

(iv) centralization of resources, and

(v) vacant sanctioned posts at the district level.

All of these deficiencies have human resource implications.

Much of the physical infrastructure is already in place. Attention will be shifted to organization and management aspects, manpower development, resource mobilization and decentralization of decision-making. Six points were raised regarding manpower development:

(i) manpower planning is essential in order to match production of personnel with requirements,

(ii) the Institute of Medicine will receive institutional support for increasing enrolment,

(iii) arrangements will be made for training in foreign countries of categories of personnel for which adequate education is not available in Nepal,

(iv) Training Centres under the Ministry of Health will receive institutional support to increase their capacity to produce manpower in the required numbers,

(v) reforms will be made in procedures for transfer, promotion and career development, and

(vi) incentives will be given to encourage doctors and other health personnel to work in rural areas.

None of the deficiencies defined or the points raised about manpower issues are new. All are congruent with the World

Health Organization's assessment of the key factors associated with the poor performance of the health sector in Nepal (Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO Management Group, 1988). What may be new is the political resolve to make meaningful changes. Panday's suggestion that a patronage system of political power inhibited the formation of a meritocratic professionalised bureaucracy and thus limited development efforts as development, with its emphasis on equity, was "inconsistent with the prevailing values" (1989, p. 327) may have been true in the past. It remains to be seen whether the political transformation is only at the level of appearances or whether real structural change has occurred.

Figure 1 illustrates the current structure of the formal health care system. Change in structure is not being advocated. Leadership is provided at the level of the Ministry of Health which has two departments (Department of Drug Administration and Ayurvedic Department) and 10 divisions (including a Division of Nursing). A Directorate of Health Services has been established in each of the five development regions in accordance with the intent of the Decentralization Act of 1982. Zone hospitals (of 50-100 beds) for each of the administrative zones provide referral services for the small (15 bed) hospitals to be established in each of the 75 districts. Each district has a District Public Health Office. Districts are divided into 9 ilakas and there is a health post offering both preventive and curative services to the rural population. In the new proposal, some ilakas have sub-health posts (but current plans do not include building new ones - ilakas with more than one health post will have one designated as the official health post and the remaining ones will be downgraded to sub-health posts) (Regmi, 1990). Specialized services, such as mobile eye clinics, are offered. More sophisticated health services are available in Kathmandu

Figure 1

Structure of the Health Care System in Nepal

Administrative	Service
CENTRAL LEVEL (Kathmandu)	
Ministry of Health	Teaching Hospital National Hospital Specialist Hospitals Army Hospital Police Hospital
DEVELOPMENT REGIONS (5)	
Directorate of Health Services	
DEVELOPMENT ZONES (14)	
	Zone Hospitals (specialist services) (50-100 beds)*
DISTRICT LEVEL (75)	
District Public Health Office	District Hospitals (15 beds)
ILAKA LEVEL (9 per district)	
	Health Centres (or health posts) (1 per ilaka) Sub-Health Posts (in some areas)

* some hospitals have more beds with 50-100 being government funded and the additional ones for paying patients or from local or other funds

which currently has a large national hospital, a teaching hospital and several specialist hospitals (i.e. a children's hospital, an infectious diseases hospital, an eye hospital, a maternity hospital, a police hospital, an army hospital, etc.). As of 1990, there were 5 districts with no hospitals. Government, mission and NGO health services in Nepal are supplemented by private hospitals and clinics which are almost invariably located in urban areas.

Expansion of health services in Nepal since the 1950s has been impressive. The analysis of issues and the plans made to address problems, as articulated in government documents, are also impressive. Unfortunately, implementation of plans has been difficult. As Mathema (1987) states:

> The health problems of the villager at present is the same as they used to be before 15 years ago. If he becomes sick his nearest approach is still a local healer in his community. A village child and a village mother still has to face with immature deaths and if they are alive their morbidity rate is high. Their earning does not allow them to have nutritious food, they are in epidemic and endemic diseases ridden environment and are under high risk of diseases. (p. 101)

The conclusion, probably accurate, is that: "On the whole, the PHC services in Nepal has still not crossed the preparatory stage" (Mathema, 1987, p. 100). Her conclusions are reached from examination of the current health status of the Nepalese population and of the weaknesses in the current delivery of health services.

What progress has been made towards improving the health status of the Nepalese people? Surveys have been done to obtain baseline statistics and targets towards the goal of Health For All by the year 2000 have been set. Provision of safe drinking water in the home or within 15 minutes of walking time and provision of adequate excreta disposal facilities either in the home or nearby are key goals. Currently, less than 10% of women are attended by health care workers during pregnancy and childbirth. The maternal mortality rate is very high at 8.5 per 1000 but a target for the year 2000 was inadvertently omitted in the planning meetings. A survey of children aged six to 36 months in 5 districts (sample size 849-890 per district) revealed extensive malnutrition. Lack of food, poor hygienic practices and intestinal parasites all contribute to the high rates of malnutrition (Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO Management Group, 1988). Child mortality was believed to be greater than 30% in the early 1980s (perhaps as high as 50% in some areas) (His Majesty's Government of Nepal in Cooperation with United Nations Children's Fund, 1982) whereas the under five years of age mortality rate was reported as 19.7% in 1989 (Maskey, 1991). A 1985 survey revealed that diarrhoeal disease is a significant cause of child mortality (HMG/WHO Management Group, 1987). Health post workers (in-charge and supervisory personnel) whom I met at a workshop attributed the rise in infant deaths in the second half of the first year of life to "weaning diarrhoea", for which they were able to give a physiological explanation. It was their belief that the introduction of solid foods inevitably causes diarrhoea. When I mentioned this belief to the nurse in charge at one of the nursing campuses, I was relieved by her immediate response that "weaning diarrhoea" is a consequence of poor hygiene and contaminated environments. Table 2 gives additional information about the 1987 situation regarding health in Nepal and the targets that have been set for the year 2000.

Regmi (1990) has concerns about the low morale of health professionals and health auxiliaries and about the division of all districts into nine ilakas with one health post per ilaka. Population per health post will vary from less than 2000 in remote areas to more than 50,000 per health post in the Terai (where transportation is also

Table 2

Health-related Statistics in Nepal: 1987 Figures and Year 2000 Targets

	1987	2000
Natural Indicators		
Infant Mortality Rate	108	45
Life Expectancy at Birth (in years)	52	65
Population Growth Rate (in %)	2.66	<2
Total Fertility Rate/Woman	5.8	2.5
Infrastructure Planning		
# of Hospitals	92	111
# of Health Posts		
static	353	141
integrated	463	675
total	816	816
# of sub-health posts	nil	4,015
# of ayurvedic units at health posts	145	675
% of essential drugs produced locally	9	60
Human Resources		
Total ratio of 1:3000 population		
Doctors	863	2,400
Kaviraj (gazetted)	22	150
Health Assistants	773	2,463
Auxiliary Health Worker	1,161	6,587
Kaviraj (non-gazetted)	160	700
Total ratio of 1:600 population		
Nurses	380	1,202
Assistant Nurse Midwives	1,808	5,000
Total ratio of 1:500 population		
Health Volunteers	4,570	48,000

Adapted from: Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO Management Group (1988)

-Immunization, family planning and maternal/child health vertical programs remain.

-Targets to reduce the incidence of TB, leprosy, malaria, malnutrition, measles, tetanus and diphtheria have been set.

easier) yet the staffing pattern will be the same. Mathema (1987) suggests that the physical presence of a health post and the assignment of personnel to work in it do not mean that the physical facilities are suitable or that the posts are staffed. Utilization of health post services is low in many areas. As Mathema (1987) reports:

> The critical findings of Joint Evaluation Report of Six Fully Integrated District 1986 shows that only little more than half of the sample household consulted health institutions and approximately 55 percent of the household did not use the health post any time during the previous year of the evaluation period. The main reasons cited for not utilising the health post were long distance (27.7 percent), non-availability of medicine (26.0 percent), ineffective service (21.1 percent) and unfriendly nature of health post staff (10.1 percent). (p. 101)

Communication and transportation are limited in some parts of Nepal. Personnel are not being produced in sufficient numbers and their training and orientation is often inadequate. Postings may be inappropriate, information needed for decision-making unavailable and community participation lacking. Public awareness of hygiene, diet and environmental pollution is poor. Scarce resources and poor management lead to problems with availability of drugs and equipment. Scarce resources and lack of a national health insurance scheme mandate that patients pay for most drugs or supplies required for care of illness but preventive services are free. Maintenance of health facilities is often ignored (Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO Management Group, 1988). Thus geographical, structural and interpersonal barriers are limiting the effectiveness of health activities in Nepal.

Reflections on the Nepalese Context

Nepal is a poor country which is heavily dependent on foreign aid and on the goodwill of India. Topographical and climatic features make transportation and communication systems difficult. Development has been slow as under the Rana regime from the mid 1800s to the mid 1900s:

> Nepal was kept under the worst form of isolation, backwardness and economic exploitation and the country remained a feudal state controlled by the Ranas. Their only interest was the collection of revenues and maintenance of law and order. It was only in 1950, in the wake of its liberation from Rana family rule, that the country emerged from a very medieval form of feudal dominance. (Bista, 1991, p. 28)

Infrastructure needed to build a modern state began to develop only in the 1950s. While the current poverty and inequities in Nepal may be deplorable, the achievements of the last 40 years are not insignificant. Services have been expanded, the political apparatus has been reformed and inequities have been exposed. Population pressures and environmental degradation have emerged as two of the major concerns confronting the nation. Building the physical structures needed to implement development strategies will not make any difference unless the human resources needed to actualize the plans are developed. Bista (1991) may or may not be correct in attributing the lack of progress in Nepal to the fatalistic attitude which he perceives as imbedded in the Hindu religion. Class, caste and gender issues do appear to mediate the power relationships within Nepalese society and, consequently, the access to resources. International priorities do influence the use which may be made of foreign aid.

Decisions are made by people. The direction of human resource development may paradoxically reveal the power relations in society while simultaneously providing the means for social transformation. While the next chapter focuses on the research process, subsequent chapters will outline current issues in human resources for health development in Nepal and the position of nurses with regard to their participation in Primary Health Care. It remains to be seen whether the changes in political structure will be truly transformative or merely remain at the level of appearances. Real political change would be catalytic in stimulating social change.

CHAPTER 4: THE RESEARCH PROCESS

In order to reveal the context in which the transition to Primary Health Care is occurring in Nepal, a case study of the changing patterns of employment and education of nurses was conducted. Data gathered were primarily qualitative in form but were supplemented from documentary evidence and quantitative data on the backgrounds of informants. Quantitative data provided scope to the research process while qualitative data provided depth. A strategy of engaging Nepalese nurse informants as co-participants or co-researchers in the research process (Moustakas, 1990) was an integral part of the research design. It was their identification and perceptions of the issues confronting nurses in Nepal which guided collection of the qualitative data.

In delineating "the dilemma of context", Scharfstein (1989) states: "A context is by definition relevant to whatever it is that one wants to explain and excludes everything, no matter how close in some way, that lacks the required explanatory power. If one thinks of it as a background, one sees that it is contrasted and paired with a foreground, and that the two are reversible" (p. 1). A similar argument would reveal the artificial nature of the microsociological/macrosociological and agency/structure dichotomies. Opposition may be theoretically useful but interaction is a more accurate depiction of reality. "A narrow concern with social structures precludes a proper understanding of the processes of interpretation through which they are reproduced and, sometimes, changed. Conversely, interactional sociology has to be aware of the real structures which constrain and enable social action. There is an urgent need to synthesize both approaches" (Silverman, 1985, p. 77). Similar arguments have been made with regard to anthropological research (Singer, 1989) and to research on Primary Health Care (van der Geest, Speckman & Streefland, 1990).

Research Design

In case-study research, there is no specific format which must be followed. The research design emerges from the questions being addressed (Polit & Hungler, 1978; Yin, 1989). Regarding the proposed research questions as guidelines allows flexibility in shifting focus if emerging data suggest other questions as more relevant to the problem being addressed (Miles & Huberman, 1984). "Critical multiplism", the thoughtful selection of research methods which approach the problem from multiple perspectives (Coward, 1990), fits nicely with case-study research. When the case study method is used as a component of theory generation, Wilson & Gudmundsdottir (1987) suggest that "the definition of a case is as much a product of the research as it is a predetermined construct" (pp. 33-34). The research process could be articulated as directed at answering the question: "What is this a case of?" (p. 44). Yin, in his ground-breaking book Case Study Research, defines a case study as:

> an empirical inquiry that:
>
> - investigates a contemporary phenomenon within its real-life context; when
>
> - the boundaries between phenomenon and context are not clearly evident; and in which
>
> - multiple sources of evidence are used. (1989,p.23)

Yin's book is an attempt to introduce some sense of scientific rigor to the case study approach which has often been criticized as a weak research strategy. He suggests that the relevance of the case study is easily defended by virtue of the frequency in which this strategy is used, particularly in international research. The strength of the approach is in allowing "an investigation to retain the holistic and meaningful characteristics of real-life events" (p. 14) and that case studies are often much more than exploratory studies. There are many examples of case studies which are both descriptive and explanatory. The concern about lack of generalizability is countered by: "The case study, like the experiment, does not represent a 'sample', and the investigator's goal is to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization)" (p. 21).

The research design selected relates directly to the five interconnected research questions. Each question will be repeated and the relevant research methods described. While ethnography, "a generalized approach to developing concepts to understand behaviours from an emic point of view" (Field & Morse, 1985, p. 21), best defines the approach taken to solicit the perceptions of the nurse co-researchers in this study, grounded theory more accurately describes the process of conduction and analysis of the interviews:

> A grounded theory is one that is inductively derived from the phenomenon it represents. That is, it is discovered, developed, and provsionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. (Strauss & Corbin, 1990, p. 23)

Factual information was gathered via questionnaire and examination of government and other related documents, including validation of my understanding of documentary evidence with key informants. A literature review on the Nepalese context was undertaken. Using multiple methods of data collection, often referred to as methodological triangulation in the literature, is consistent with much case study research but may pose problems for data analysis if the research process is inadequately conceptualized (Mitchell,1986).

Research Questions and Related Research Strategies

(1) What model of Primary Health Care is being implemented in Nepal?
(2) How have nurses been incorporated into the model?

These questions were addressed by examination of the country health plan and other government documents and by interviews with nursing faculty as well as with the nurse at the highest level in the health system bureaucracy. As nursing education falls under the aegis of the Institute of Medicine at Tribhuvan University, the former Dean of the Institute of Medicine (a new Dean was appointed while data were being collected) was interviewed.

(3) How has nursing education changed in response to the focus on Primary Health Care?

The curricula preceding the integration of the Primary Health Care concept for both the certificate and baccalaureate nursing programs were examined and compared with the current curricula in terms of content, clinical experiences and teaching methods. My perceptions of changes were validated with faculty. Curricula designed to facilitate nursing involvement in Primary Health Care were implemented at the certificate level in 1987 and at the baccalaureate level in 1989. All certificate schools of nursing in Nepal follow a national curriculum and there is only one baccalaureate nursing program in the country.

(4) What do nursing leaders, educators and students in Nepal

identify as key factors which constrain or promote nursing effectiveness in Primary Health Care?

Students and faculty were administered questionnaires which included some open-ended items. Faculty and nursing leaders were asked to participate in unstructured interviews. Nursing leaders were those nurses not employed in the institutions included in the sample who other participants identified as persons with whom I should speak. In reality, most of the identified nursing leaders were employed in faculty positions. Exceptions were the senior nurse in the Division of Nursing, Ministry of Health, a nurse employed in a position equivalent to District Health Officer for the United Missions of Nepal and informal discussions, not taped interviews, with the two World Health Organization nursing advisors. The president of the nursing association was one of the faculty members interviewed.

(5) What are the structural features both enabling and constraining effective nursing involvement in Primary Health Care?

Students and faculty were asked to complete short structured questionnaire items. Information from these questionnaires was synthesized with the qualitative data from interviews and open-ended questionnaire items as well as documentary evidence. I had hoped to share the preliminary analysis with groups of students and faculty to see whether the synthesis of material accurately and adequately captured their experience so that additions and modifications suggested by the groups could be incorporated into the findings. Meeting with groups proved impractical for several reasons. Participants faced time constraints as class time was not available and faculty and students were usually busy on the one day off they have per week. In addition, I was in Nepal for only six months and data were still being collected until the last few days. Consistent with grounded theory methodology, however, perceptions about early findings were shared and validated in subsequent interviews.

In addition, fieldnotes of my observations and insights were maintained. Field visits were made to sites where clinical experiences were being provided for students, although time constraints made this data collection strategy a peripheral part of the study. These field visits, as well as other chances to observe or participate in faculty activities, provided opportunities for incorporating some participant-observation into the research design. A diary of my perceptions and frustrations with the research process was kept. A literature review of the Nepalese context was conducted.

Selection and Sampling

In ethnographic research, selection "is a developmental, ad hoc procedure rather than an a priori parameter of research design" complicated by "the necessity of selecting for internal accuracy and external applicability" (Goetz & LeCompte, 1984, p. 69). Definition of the population and the initial sample is important for practical reasons but boundaries remain fluid and selection processes are viewed as "dynamic, phasic,and sequential (Zelditch 1962) rather than static" (p. 69). The sampling rules designed for quantitative research do not apply. The guidelines for addressing sampling issues are often confusing yet "the selection of a sample has a profound effect on the ultimate quality of the research" (Morse, 1989, p. 117). Sampling decisions must be made but approaches may evolve as the data collection proceeds.

Nurses and student nurses in Nepal comprised the population for this study. A decision was made, however, to focus data collection, at least initially, at the level of nursing education rather than nursing practice. This decision was made in cognizance of the fact that Primary Health Care, the focus of the study, was only integrated into the certificate nursing curriculum in 1987 and that the literature suggested that involvement of practising nurses in Primary Health Care has been limited, at least until recently.

Ideally, all student nurses and all nursing faculty in the country would have completed the questionnaires, as recent expansion of nursing education to peripheral areas of the country could mean that nursing students are being recruited from different regions and differ in key characteristics. Except for certificate level student nurses, the numbers are small. Thus a decision was made to try to gather population and not sample data. Questionnaires were completed by 80 faculty, 33 baccalaureate students, and 636 certificate students and included respondents from all nursing campuses. Response rates were 73%, 56% and 92%, respectively.

Sampling for interview informants (co-researchers) followed guidelines suggested by Morse (1989). Purposive (theoretical) sampling, according to the needs of the study, was adopted. Thus initial informants, faculty members, were invited to participate because of their known interest and involvement in preparing nurses for roles in Primary Health Care. As the study progressed, the guidance of identified informants was sought in identifying individuals who might wish to participate and who had relevant knowledge and experience. As data accumulated and themes emerged, informants with specific knowledge about certain aspects of nurses in Primary Health Care were approached to participate. Informants known to have views diverging from the majority were also approached in order to collect information regarding negative cases. Good informants were knowledgeable and articulate and time was not wasted in prolonging interviews with poor informants. The sample size could not be estimated *a priori* but depended instead on the "appropriateness" and "adequacy" of the data obtained. Was understanding of the research problem emerging from the analysis of data? Had saturation, the point of no longer hearing anything new, been attained? If so, the sample was appropriate and adequate and no further informants were required. Forty formal interviews were conducted, of which 33 were audio-taped. While most interviews were with individuals, one of the audio-taped interviews involved four co-researchers and one involved two co-researchers. Of the interviews which were not audiotaped, there was one with three co-researchers and one with two co-researchers. In all of the multiple interviews, at least one co-researcher had already been interviewed individually and the participants chose a group interview. Of 44 interview co-researchers, 7 were expatriates while 37 were Nepali. The expatriates were in Nepal under the aegis of the United Mission to Nepal (multinational), Peace Corps (American) or Volunteer Services Overseas (British). A minimum of two Nepalese faculty members were interviewed at each nursing campus. In addition to the formal interviews, several informal discussions were held with faculty members.

Assumptions

Assumptions inherent in the research approach and delineated prior to data collection were substantiated during the fieldwork and remain unchanged. They include the following ideas:

(1) Knowledge is embedded in experience.

(2) Tacit (intuitive) knowledge may not be consciously perceived.

(3) Dialogue may stimulate the recognition of previously unconscious knowledge.

(4) The meaning attributed to knowledge, behaviour or attitudes is not universally shared.

(5) Meaning is derived from past and present experience in conjunction with future expectations.

(6) Researcher subjectivity drives all phases of the research process and is always a potential source of bias while paradoxically also being a potential source of insight and creativity.

(7) Knowledge of the literature affects the researcher's subjectivity and may either increase or decrease researcher bias.

Field Research Issues

From my perspective, the field experience went more smoothly than anticipated. It is my belief, however, that the six months was the minimum time required for meeting the research objectives. I arrived in Nepal on September 15, 1991 and departed on March 15, 1992.

Entry into the research setting and access to the required documents were facilitated by personnel at the Institute of Medicine. Permission to contact the Campus Chiefs of all Nursing Campuses was received within a few days of my arrival in Kathmandu. My proposal had been read by the Director of the Nursing Education Unit and by the World Health Organization Nursing Education Advisor. A letter sent to them before my arrival in Kathmandu had outlined the type of documentary information which I hoped to access and the necessary reports and curricula had been gathered for me. I had been informed of the Dasain holiday (all Nursing Campuses were closed from October 8 to November 10, although administrative staff were at work during a portion of this time). Thus my first priority was to find a place to photocopy my questionnaires and to access a site for pre-testing of my questionnaires prior to the commencement of the holiday. A decision was made not to start interviews until faculty returned in November. Fieldwork issues did not arise in chronological order as much as centre on issues relating to the data collection methods and issues related to contacting persons and setting appointments. Acquiring a Research Visa was also an issue as the maximum stay in Nepal on a Tourist Visa is four months.

Collecting Documentary Data

This information was easily acquired and posed few problems. New curricula were implemented for certificate level nursing students in 1987 and baccalaureate level nursing students in 1989. The new curricula represent a shift towards preparing nurses for a variety of roles in a Primary Health Care model of health services. I was able to access all prior baccalaureate curricula, the certificate curriculum immediately preceding the current one, and both current curricula. These curricula allowed me to examine how nurse educators were conceptualizing the potential for nursing involvement in Primary Health Care and the knowledge, skills and attitudes the nursing education system was designed to impart.

Other documents examined were ones published by His Majesty's Government of Nepal, the Ministry of Health and the World Health Organization and related to manpower planning, health priorities and country health plans. In addition, a faculty member at Maharajgunj Nursing Campus, who has spent many years with the United Mission to Nepal, lent me a copy of her master's thesis which looked at nurses and Primary Health Care in Nepal. Several recent books on development issues in Nepal were purchased as an aid to interpreting my data. These documents, except for the ones brought back to Canada, were examined during lulls between other data collection activities.

Field Visits

Seven Nursing Campuses in Nepal offer certificate level nursing programs and one of these campuses offers a post-basic baccalaureate program. Two other campuses which offer the assistant nurse midwife program were not included in the sample. Three campuses are in the Kathmandu Valley, one is 200 kilometres west of Kathmandu and three are near the border with India (see Appendix 11 for map). Field trips were made to all seven schools of nursing. Making contact to arrange visits was relatively easy for the campuses in the Kathmandu Valley but difficult for the other sites as mail service is unreliable and people were difficult to contact by telephone for reasons which included long periods of absence from the campuses. My wish to visit clinical sites was made clear in my letters to Campus Chiefs as was my desire to administer questionnaires to students and faculty and to interview faculty.

The Dasain Holiday extended from October 8 to November 10 and no data collection was possible at that time as students and faculty were absent. There was another long holiday in January. There were also many one day holidays and these were sometimes arranged only a day or two in advance. This affected data collection at three of the sites outside of the Kathmandu Valley. At one nursing campus, one class of students was totally unavailable because a change in the start of the January holiday coincided with my field trip to that site. The Campus Chief at this site was very apologetic and offered to administer the remaining questionnaires for me when the students returned from vacation. This was done very competently. Consequently, only two interviews were done at this site.

These holidays, however, had other effects. Each class of students has one study day a week and spends five days a week in clinical practice. Thus questionnaires had to be administered on study days. Faculty accompany students to clinical facilities. Thus interviews also had to be done on study days. When holidays were unexpectedly announced, the time available to visit clinical sites seemed to disappear. It had been arranged that I would go to the rural health posts where students gain experience while in Biratnagar and Nepalgunj but these visits got cancelled. I did go to the government hospitals in Nepalgunj and Biratnagar and to three hospitals in the Kathmandu Valley but all health posts visited were in the area of the Kathmandu Valley. My information suggests very strongly that facilities away from the capital are in poorer repair and much more poorly supplied and staffed. Four consecutive shifts were spent with faculty and certificate students during their pediatric clinical experience at Kanti Hospital, the only children's hospital in Nepal.

Questionnaires

Three questionnaires were developed; one for certificate student nurses (Appendix 111), one for baccalaureate student nurses (Appendix 1V) and one for faculty (Appendix V). Both forced-choice and open-ended items were included. The questionnaires were short and only questions that respondents were likely to be able and willing to answer were asked (Sheatsley, 1983). Where possible, the questionnaires were administered to groups of respondents by the researcher so that clarification of questions could be made (Dillman, 1983). In practice, this was not always possible. Questions asked related to issues that the literature on Primary Health Care suggested as barriers to nursing participation or were designed to assist in development of profiles of students and faculty. It was recognized that English was not the first language of most respondents and items were worded as clearly and simply as possible using principles of questionnaire construction suggested by Sheatsley (1983) and hints about doing social research in developing countries offered by Pausewang (1973). Anonymity of respondents was preserved by using the method described by Damrosch (1986) for generating identification codes (Appendix V1). These codes allowed subjects to generate their individual identification codes in a manner which can be replicated with almost perfect reliability but which makes it almost impossible for the researcher or anyone else to break the code. The purpose was the preservation of anonymity in a manner which could provide linkage for longitudinal data from the same subjects. In retrospect, I would question using the self-generated identification codes again unless a longitudinal study was planned as the process increased the time needed to participate as questionnaire respondents and created confusion among some students.

Validity and reliability are issues in questionnaire development. Reliability includes issues regarding clarity of items and replication of responses. The questionnaires were administered to three Nepalese nationals living in Canada for input regarding wording and sensitivity to cultural issues. A fourth Nepalese national living in Canada, a nurse with experience teaching nurses in Nepal, was invited to complete all three questionnaires and respond regarding clarity, wording, sensitivity to cultural issues and content. Content validity was also assessed by two Canadian nurses with experience in Nepal.

It was necessary to pre-test the questionnaires to see whether subjects understood them clearly or whether translation into Nepali was required. By September 23 (my second week in Nepal), I had permission to pre-test the questionnaires at Maharajgunj Nursing Campus. The pre-testing was done on September 29 with mixed response. I had asked to have access to 20 certificate level students, 10 baccalaureate students and 10 faculty. Pre-testing was completed with 16 certificate level students, 10 baccalaureate students and 5 faculty. The pre-testing went well. Faculty had no difficulty with their questionnaire and all faculty responded in English as did all students in the pre-test group. Some students appeared to experience difficulty but they were adamant that the questionnaires remain in English (nursing examinations in Nepal are all in English). It was agreed that an option to respond to open-ended questions in Nepali should be made clear on the questionnaire. Minor changes were made in a couple of questionnaire items after the pre-testing but the questions remained substantively the same. Students outside of the Kathmandu Valley appeared to have the most difficulty with English and a strong argument could be made that the student questionnaires should have been translated into Nepali.

Administering the questionnaires was difficult at some Nursing Campuses. The questionnaires took approximately 60 minutes to complete but an additional 15 minutes were needed to explain the research to the students, get the consent form signed and have them create the self-generated identification number. While this was made clear to Campus Chiefs, at some institutions insufficient time was allocated. Students were given the questionnaires to complete at their own convenience. The returns were very high at campuses where sufficient class time was allocated (100% at three sites). At one campus, I had to meet with students to explain the research and get the consent forms signed and the identification numbers generated and then have the students complete the questionnaires at home and return them to me for part of the student population. This is also the way in which almost all baccalaureate level and faculty questionnaires had to be administered. Returns diminished when this kind of questionnaire administration was used.

The lowest return was from baccalaureate level student nurses. These students were post-basic and often had heavy family responsibilities which may have made responding to the questionnaire on their own time very difficult. Only 33 out of 59 students completed the form. With faculty, 80 questionnaires were returned out of an estimated population of 110. This is an estimation as accurate figures were not obtained from at least one site. Several faculty were on leave or not teaching at the site where they were officially employed. The returns from certificate students were very good with 636 forms completed from a population of 692.

I have a few thoughts about data collection with this population which I would like to share. I did not initially conceptualize the questionnaire data as the most important part of this project. The interviews were. While I have not changed my opinion, the questionnaires were more important than at first imagined. Several nursing faculty have advanced degrees but they had backgrounds mostly in quantitative research. The questionnaires legitimized my research for them. The gathering of questionnaire data also increased my time with faculty which I believe enhanced their trust in later interviews. Student involvement was also increased as was faculty involvement because not all faculty were interviewed. Completing questionnaires may have enhanced some faculty thinking about issues which again may have increased the quality of interviews. Having said this, I have concerns about the accuracy of some of the questionnaire data. Students did not respond independently as there was much discussion during completion of the forms. This should not affect most items but did affect open-ended questions. Should the forms have been in English or Nepali? All faculty and baccalaureate students answered in English but approximately 35% of certificate level students responded to at least some items in Nepali. Questions raised during questionnaire administration often related to conceptual rather than language problems in terms of understanding the question. Asking students to project into the future was an area of difficulty as one student wrote that in Nepali culture they do not think of the future. The question most often left unanswered was the one related to ethnicity. Sometimes students did not understand the question but it must also be acknowledged that it may be a sensitive issue.

The other issue that could be raised is whether sampling of certificate level students would have sufficed. Because I wished to ascertain the backgrounds from which students were coming and because regional differences may have been significant and most of the student population is at the three schools in the Kathmandu Valley, I decided to remain with population figures. The three schools in the Kathmandu Valley also differ significantly. Maharajgunj is large and offers both certificate and baccalaureate programs. Lalitpur, while under the aegis of the Institute of Medicine, is a mission school. Bir Hospital is the only Nursing Campus not under the aegis of the Institute of Medicine. It is a new school of nursing and has not yet had a graduating class and is under the aegis of the Ministry of Health. It was created because the Institute of Medicine was not able to expand programs as quickly as the Ministry of Health desired.

Interviews

The interviews were of prime importance to this research but the open-ended questionnaire items were also useful in identifying many of the same issues. Interviews allowed more in-depth exploration. The selection of informants (co-researchers) has already been described. The term co-researcher was used deliberately as it was my wish to mutually explore the issues related to nursing involvement in Primary Health Care rather than provide direction for the parameters of the problem. Thus an unstructured interview format was chosen. The emic (subjective) view was sought and it was the meaning placed by social actors on phenomena that was important to ascertain from the interview data. Some co-researchers were skilled at articulating both their subjective views and an objective assessment of alternate views in the society. Understanding of phenomena was the goal and not mere description of factual information. Much has been written on the ethnographic interview (Field & Morse, 1985; Spradley, 1979; Werner & Schoepfle, 1987a) including the use of self in the process (Denzin, 1989; Lipson, 1989; Mishler, 1986; Moustakas, 1990) and the issue of subjectivity versus objectivity (Goetz & LeCompte, 1984; Peshkin, 1988).

Many interactions with people in Nepal added to my knowledge and understanding of the Nepali context. I did, however, conduct 40 interviews where the stated purpose of the interaction was to gather data for my research. Of these interviews, 33 were audio-taped. Only two persons refused to be audio-taped. The other 5 interviews were not audio-taped partly because of interview issues that will be discussed later. All 33 audio-taped interviews have been transcribed. Eleven are in summary form and 22 are verbatim.

Very early a major issue regarding interviews became evident. The first three interview appointments were not kept and I wondered whether nurses did not wish to be interviewed but did not want to tell me. Two of these people approached me the next day and were interviewed. The other person was never audio-taped but two informal interviews were done spontaneously when we met at later dates. There were never any more problems with appointments not being kept without the nurse contacting me in advance about changes. There was a reluctance, however, to make appointments. Major meetings are often not planned in advance so it was difficult for faculty to predict when they might be available. Thus planning ahead for interviews was difficult and often not possible. I learned to carry my tape-recorder and audio-tapes with me during all visits to nursing campuses. Being given an office at Maharajgunj campus near the end of November facilitated my interviewing of faculty at that site. Finding appropriate space for audio-taped interviews was never a major issue. Some faculty apologized for their lack of facility in the English language but my feeling was that there was no way that in six months I could reach a similar ease in Nepali and that use of a translator would decrease interaction as most faculty spoke fair to good English. Only in two interviews did I feel that lack of ease in English posed a significant problem. Many faculty had done part of their education outside of Nepal and were fluent in English. Students appeared more confident writing English than speaking it.

Transcribing my own audio-tapes was difficult because of time constraints but finding assistance for this was problematic as confidentiality, access to a computer and the relevant computer skills and facility with English were all requirements. Consequently, the first 11 audio-tapes were summarized and not transcribed verbatim as I needed to do some preliminary analysis at that point in order to plan how to proceed with subsequent interviews. I returned to Canada without summarizing or transcribing the last 11 audio-taped interviews. Transcribing was extremely time-consuming and was sometimes on hold because of interruptions in the electricity supply.

While it would have been desirable to interview the most knowledgeable and articulate participants on more than one occasion, this could not be arranged. Informal discussions, however, were held with many co-researchers in addition to the formal interviews. It was anticipated that the most substantive insights from this research would emerge from the interview data. No interview guide was constructed for the initial interviews but subsequent interviews were planned based on emerging themes. Interview techniques suggested by Spradley (1979) and Werner and Schoepfle (1987a) provided useful guidelines. While these researchers conceptualized the interview process in slightly different ways, the basic approaches were similar. Spradley suggested starting with descriptive questions and, when categories began to emerge, to start asking questions relating to structure. These questions often require explanations. Contrast questions, designed to elicit meaning and differentiate boundaries, follow structural questions. Early interviews should focus on descriptive questions and the use of structural and contrast questions should increase as completed interviews are analyzed and incorporated into the researcher's perceptions of the phenomena under study. Werner and Schoepfle write of grand tour questions which are useful for building confidence and rapport and mini tour questions which are more focused and intended to solicit information related to the structure of information given in response to more general questions. Five categories of grand tour questions are identified as those soliciting responses about: space, actors, job descriptions, time and, after rapport has been established, about feelings and evaluations. All question types are perceived as equally important. Using these guidelines, initial questioning focused on where nurses were working and what they were doing in the health care system in Nepal. Later questioning focused on what co-researchers would like to see nurses doing, what they perceived as major issues within the profession, what forces were influencing nursing participation in health care at all levels, what they would like to see happening, how they felt about their current level of involvement, what might change the current situation and what they perceived for nursing in the future, including what could be done to realize their goals.

Participant - Observation

Participant - observation was only a minor aspect of this research and I hesitate to use the term. My hope was to access some clinical settings and to keep fieldnotes of observations which appeared relevant to the phenomena of interest. Immersion in the culture of nursing in Nepal was not attempted. Thus fieldwork as described in the literature (Shaffir & Stebbins, 1991; Spradley, 1980) was not envisioned although the guidance provided for entering the field setting and recording observations was useful.

My original intent was to try to find an apartment in Kathmandu and thus reduce living expenses. This was considered impractical by a Nepali who was helping in my search for living space. Consequently, I stayed at a hotel for the six months. In hindsight, being a guest at the hotel offered opportunities for informal data collection. Hotel staff communicated different facets of their lives to me, the owners included me in many of their activities and other guests talked about their projects and invited me to observe in areas to which I otherwise would not have had access. The hotel was small and frequented mostly by business people and expatriates associated with aid organizations or the Institute of Medicine and was not a popular tourist place. The interactions with the people whom I met at the hotel were not part of the formal data collection process but rather these associations have been invaluable in some of my interpretation of data. Invitations to visit Nepalese homes were also helpful. My decision to spend time at Kanti Hospital with students and faculty led to a much different perception of nursing activities than I had received from guided tours of facilities.

Personal Diary

The decision to maintain a personal diary of subjective feelings and experiences was reinforced by Peshkin's (1988) description of "tamed subjectivity" and its value as a research tool for revealing one's biases via a monitoring of one's reactions as data are being collected. Peshkin claims that researcher subjectivity can mute the emic voice but that awareness can obviate the difficulty. Tamed subjectivity has potential as a research tool as "it is the basis of researchers' making a distinctive contribution, one that results from the unique configuration of their personal qualities joined to the data they have collected" (p. 18).

Obtaining a Research Visa

I am certain that I would never have received my research visa had I remained in Canada. The information that the secretary of the World Health Organization Nursing Education Advisor was receiving when he enquired about my visa status was inaccurate. The application had been lost and it was only when I went to the research office at Tribhuvan University that we were informed about the missing documents. This secretary was very knowledgeable about bureaucratic processes in Nepal and had excellent interpersonal skills. At each agency (Tribhuvan University, Ministry of Education, Ministry of Immigration) he had to persuade individuals to sign forms so that the application could be moved to the next level of the bureaucracy. At one agency, he actually dictated the letter of approval to a secretary and then returned to the person whose signature was required and persuaded him to sign it. Thus I believe that I was extremely fortunate in having the institutional support needed to obtain the visa. This level of institutional support was also crucial to my access to all data sources and accounts for the minimal blocks that were encountered in data collection.

Data Analysis

Guiding my plans for data analysis was the call for what Noblit and Engel (1991) have named the "holistic injunction" (p. 123) as both an ideal and a moral imperative for qualitative research. As such, qualitative work is "emic, comparative, historical and holistic" (p. 124) with analysis being directed toward revelation of the deep structure of data and not surface appearances. Analysis must go beyond description to interpretation. Understanding must be contextualized and thus "translated" into a meaningful whole (Turner, 1980). In discussing ethnographical reports, Atkinson (1990) suggests that "ethnography itself is a genre which is held, paradoxically suspended, between the humanistic and the sociological, the subjective and the non-subjective. A close reading of the texts will deconstruct them in the revelation of this paradox" (p. 8). The process of data analysis is complex and must be guarded against reductionism. The question becomes how to proceed.

As Yin (1989) asserts: "The analysis of case study evidence is one of the least developed and most difficult aspects of doing case studies .... much depends on an investigator's own style of rigorous thinking, along with the sufficient presentation of evidence and careful consideration of alternative interpretations" (p. 105). Yin suggests that the preferred strategy is to rely on the theoretical propositions underlying the development of the research process while the other acceptable strategy is the development of a case description. Either strategy will include attention to the analytic techniques of pattern-matching, explanation building and time-series analysis. The problem of data analysis in this case study is compounded by the triangulation of quantitative and qualitative research strategies (Mitchell, 1986). It was at this point in the conceptualization of the research question, and after completion of data collection and preliminary data analysis, that I had to ask myself a very difficult question. Do any implicit theoretical propositions underlie this case study? The honest response is a qualified yes. Three were identified. (i) Context shapes nursing contributions to health care. (ii) Power structures are integral components of context. (iii) Social actors can influence or mediate context. Why must these propositions be qualified for purposes of data analysis? In defining and analyzing documentary and questionnaire data, they guided the process of analysis. In analysis and interpretation of qualitative (interview) data, these propositions were more appropriately considered biases. Thus interview data were analyzed and interpreted in isolation from all other data before synthesis of findings was attempted.

Some data analysis methods have already been alluded to in the description of tools for data collection. Content analysis was done for documentary information followed by clarification by co-researchers as required. Diary notations were examined for evidence of systematic ways of responding to particular inputs in order to bring into awareness my subjectivity and learn to control it in interview and data recording processes. Fieldnotes added to my knowledge of context and generated ideas of avenues to explore in subsequent interviews in order to check my observations and interpretations with co-researchers. Quantitative and qualitative data from questionnaires were coded and descriptive statistics were generated by computer in order to develop profiles of students and faculty. Two Nepalese research assistants were hired and trained to assist with translation and coding of questionnaires. All items were double coded to check consistency. No inferential statistical procedures were done for this study. It was accurately anticipated that analysis of the interview data would pose the most difficult challenge.

Analysis of the interview material was an on-going process which began with transcription of the first audio-tape which should have been done prior to any subsequent interviews. This is a tenet of qualitative analysis with which there appears to be little disagreement (Denzin, 1989; Field & Morse, 1985; Goetz & LeCompte, 1984; Miles & Huberman, 1984; Moustakas, 1990; Spradley, 1979; Spradley, 1980; Stern, 1989; Strauss & Corbin, 1990; Werner & Schoepfle, 1987b) but which proved impossible to implement for this study. Because of severe time constraints related partly to the two prolonged holiday periods during my time in Nepal, 11 interviews were completed before any transcription of audio-tapes was accomplished. More controversial, however, was how to proceed next. Concern with scientific rigour has led some researchers into the trap of content analysis and quantification of qualitative data with the result that reductionistic descriptions of phenomena may be generated and the richness of the raw data lost (Stern, 1989). Voluminous data were generated and there was a need to develop strategies for making the data manageable without losing sight of the whole picture.

Data analysis was a continuous process during the period of data collection as immersion in transcribed data coincided with subsequent interview processes whenever possible. Coding, categorization and conceptualization began with the initial interview and it was necessary to develop a mechanism for "filing" data in a retrievable form for future reference (Field & Morse, 1985). Various strategies have been suggested (Miles & Huberman, 1984). While I had access to a computer with an ethnographic software package while in the field, data were not initially transcribed in the appropriate form for two reasons. I was unable to access the appropriate size of computer paper for my printer in Nepal so had to rely on supplies brought with me and sent by friends. Ethnograph format is one which does not conserve paper. Thus interviews were transcribed and printed using Word Perfect while in Nepal and reformatted for ethnograph on return to Canada. Time was the other constraint. It was at a premium in Nepal and I was much more familiar with the Word Perfect program. Analysis of qualitative data is a creative process and, therefore, the limitations of computer analysis must be recognized. Ethnograph is a filing and retrieval system only. Decisions regarding coding are made by the researcher.

Initial coding was related to the research questions (Ammon-Gaberson & Piantanida, 1988) with particular attention to remarks which identified or illuminated the context within which nurses in Nepal are becoming involved in Primary Health Care. I was already aware of a strongly intuitive and subjective bias regarding the centrality of power as a concept and the intersection of structure and agency as integral to the analysis. Every effort was made not to ask leading questions which would cue co-researchers as to this bias until related information had emerged from preceding interviews.

In transforming the data into a meaningful construal, Ammon-Gaberson and Piantanida (1988) use the analogy of a mosaic and suggest that "the meaning of a construal arises from the arrangement of data in a way that transcends the significance of the raw data bits" p. 160). Data are "sifted", "sorted" and "shuffled" until a meaningful picture of the phenomena, including relationships of the parts to the whole, is created. Early in the analysis classification is likely to be imprecise and flexibility in conceptualizing categories must be maintained. Premature closure must be prevented in the translation from data analysis to data interpretation. Premature closure occurs when insufficient data are collected (thin sampling) or when analysis ceases before all possibilities have been examined and before "a solid construal can be explicated" (p. 160). While this process of handling data appears vague, it fits closely with the goal of this research. More concrete, and perhaps more helpful, was the discussion of grounded theory methods by Strauss and Corbin (1990). Methods of open coding (lateral thinking strategies for defining and breaking down categories), axial coding (strategies for creatively synthesizing data after open coding) and selective coding (selecting the core category and relating all other relevant categories to it) were explained as well as the use of memos in the form of code notes, theoretical notes, operational notes and diagrams. These strategies were incorporated into the process of data analysis. The final construal includes synthesis of this interview data with other data generated by the research process. All interview transcripts were read an additional time after the data were analyzed to ensure that no concepts imbedded within the text had been missed.

Ethical Considerations

Qualitative research raises ethical questions beyond the basic tenets of safety, anonymity, confidentiality, informed consent and researcher responsibility and competence as outlined in the University Policy Related to Ethics in Human Research (University of Alberta, 1985). Technical issues were relatively easy to resolve. Questionnaires have been identified by codes and not names and aggregate data have been reported. Informed consent was obtained in writing (Appendix V11). Data were stored under lock and key, audio-tapes will be erased on completion of the research process and, as with copies of the transcripts, have been identified in coded form (Bergum, 1989).

Written informed consent was obtained from the interviewees (Appendix V111) but the issues were more complex (Robinson, 1991; Robinson & Thorne, 1988) as were the issues related to confidentiality (Field & Morse, 1985; Robinson, 1991). In ethnography, the thrust of the research and the relationships between researchers and informants may change over the course of the contact. Relationships of trust may lead informants to reveal more than they wish or to reveal information which, if reported, would threaten anonymity and compromise the social position of the informant. With ethical decision-making, in collaboration with informants, sensitive information may not be reported. There was a small amount of information shared with this researcher which has not been used for ethical reasons. Informants were informed that they had the right to withdraw from participation in the study and that information previously revealed would be removed from analysis on their request. Sensitive information was reported only with the explicit consent of the participant. Data were pooled or disguised in order to protect the identity of participants. A Reseach Visa was obtained and permission to conduct research was granted at Tribhuvan University and the Institute of Medicine.

Research Standards

Much has been written about the issue of standards for qualitative research (Brink, 1989; Field & Morse, 1985; Goetz & LeCompte, 1984; Howe & Eisenhart, 1990; Phillips, 1987; Robinson & Thorne, 1988; Sandelowski, 1986; Strauss & Corbin, 1990; Yonge & Stewin, 1988). Some discussions focus on issues of reliability and validity but there is increasing awareness that traditional tests, developed for quantitative research methods, are inadequate for assessing the merit of qualitative studies (Howe & Eisenhart, 1990; Phillips, 1987; Sandelowski, 1986; Strauss & Corbin, 1990; Yonge & Stewin, 1988). Yet there is an imperative to assess quality. As Miles and Huberman (1984) state: "qualitative analyses can be evocative, illuminating, masterful, and downright wrong" but "there are no canons, decision-rules, algorithms, or even any agreed-upon heuristics in qualitative research to indicate whether findings are valid and procedures robust" (p. 230). Howe and Eisenhart (1990) have suggested that the notion of standards for research, qualitative or quantitative, should replace the concepts of reliability and validity in the assessment of all research. Four evaluative criteria are suggested:

(1) Fit: Procedures for collection and analysis of data should be compatible with and be driven by the research questions.

(2) Competence: Technical competence in tool development, data collection techniques and data analysis methods must be ascertained.

(3) Credibility: Judgement of whether "warranted conclusions" have been drawn includes comparison with pre-existing knowledge, congruency of background assumptions with the research questions and methods, revelation of researcher subjectivities and "being alert to and being able to employ knowledge from outside the particular perspective and tradition within which one is working, and being able to apply general principles for evaluating arguments" (p. 7). A criterion of credibility is audibility. "Audibility is achieved when the researcher leaves a clear decision trail concerning the study from its beginning to its end" (Sandelowski, 1986, p. 34). The logic of the researcher is laid bare for the reader.

(4) Value Constraints: External value constraints pertain to the worth or practical significance of the

research, including the dissemination of findings in appropriate forms to relevant individuals or groups. Internal value constraints pertain to ethical issues. Protection of informants may preclude the collection or revelation of data that would increase warrant by substantiating the conclusions drawn.

These criteria of fit, competence, credibility and value constraints are consistent with and complemented by Yin's (1989) discussion of the characteristics of an exemplary case study. The case study must be significant and complete (boundaries defined, evidence exhaustively collected from multiple sources and data collection not constrained by limitations of time or money). Alternative perspectives must be considered and sufficient evidence displayed to substantiate the conclusions reached. Finally, the report should be written in an engaging and creative style.

Limitations

Limitations are being discussed in relation to research standards and the evaluative criteria suggested by Howe and Eisenhart (1990). I believe that the criteria of fit and value constraints were met. With regard to competence and credibility there are some limitations. While the data collection methods were not new to me, I hoped to develop more skill in data analysis than in my previous qualitative research study. Being in Nepal while my committee was in Canada hampered discussion and sharing of insights, concerns and issues regarding ongoing data collection issues. As this must be of concern for a neophyte researcher, it was important to establish some mechanism for communication with committee members. Having access to a FAX machine at the hotel where I lived was helpful. More helpful was a visit to Nepal by one of my supervisors in February (a month before my return to Canada). Having a contact person in Nepal (someone familiar with qualitative research but not directly involved with the health care system) would have been helpful. Because of the possibility of interview informants being identifiable, I believed that it was most ethical if I transcribed the audio-tapes myself. This was a time-consuming process and it was not possible to transcribe and open code all interviews before conducting subsequent interviews. Maintaining a diary was a check regarding subjectivity but not a total safeguard. The quality of the research has rested very much in the nature of the skills that I brought to the effort and the guidance which I was able to obtain. Participants will be given access to a copy of the finished thesis but will not have an opportunity to critique the findings and conclusions before completion of the dissertation. Their responses will be incorporated into any further analysis and presentation of data. Preliminary findings were discussed with the co-researchers.

Gaining the trust of co-researchers could have been difficult because of cultural barriers but was facilitated by our common identities as nurses, as women and as faculty members as I also have experience in nursing education. I also had much support from nurses in the administrative structure of nursing in Nepal and this enhanced my access to faculty and students. Communication may have been hampered because interviews were in English which was not the first language of most participants. Questionnaire data may have been more affected, particularly responses to open-ended questions, in spite of the opportunity given to respondents to reply in either English or Nepali.

The decision to interview mostly nursing faculty could be challenged as the input of assistant nurse midwives and of Ministry of Health officials could have provided additional perspectives. This limitation is acknowledged. The decision not to include these personnel was both practical (in terms of time and resource constraints) and deliberate (in terms of an emphasis on the emic perspective of professional nurses).

Reflections on the Research Process

Data collection in Nepal was challenging and rewarding and I emerged from the process with a profound respect for the nurses I met. Reflection on the data in its preliminary form as data collection was proceeding left me with a few impressions which I would like to share before presenting the findings. While the context in which nurses work in Nepal is different in many respects from that in Canada, the issues of importance to nurses were often very similar. The importance of the historical perspective, and therefore of time, kept intruding itself into my consciousness. The changes in health care seen by many of the nurses interviewed were remarkable and may partly account for what seemed to be generational differences which emerged from the perceptions of the interview co-researchers. Finally, the research process itself appeared to be a tool for raising the consciousness of all participants, myself included, in examination of issues from different perspectives.

One further thought intrudes. It is often stated that nurses lack unity (World Health Organization, 1989c). Access to conduct my research in Nepal was achieved through use of a nursing network. A nursing faculty member from Maharajgunj Nursing Campus in Nepal was a master's student at the Faculty of Nursing where I am employed. A colleague had done a workshop for nursing faculty in Nepal and had been invited to return. The WHO Nursing Education Advisor had completed a master's degree at the University where I am employed and, while I had never met her, one of my committee members knew her. One of my colleagues in Canada knew another faculty member at Maharajgunj Nursing Campus from their shared time as graduate students in Wales. All of these contacts were instrumental in gaining access to conduct the research and in being introduced to co-researchers during my time in the field. Use of a nursing network was crucial to completion of this research.

The remainder of this dissertation will focus on the presentation, analysis and interpretation of the research findings. The next chapter has been constructed from documentary evidence and outlines the development of human reesources for Primary Health Care in Nepal.

CHAPTER 5: THE DEVELOPMENT OF HUMAN RESOURCES FOR PRIMARY HEALTH CARE IN NEPAL

Human resource development includes attention to the quantity and quality of the various categories of personnel produced as well as the roles they are expected to assume. It has recently been suggested that setting international standards for the education of doctors may conflict with the needs for Primary Health Care and that a concept of national standards is more appropriate (Blizard, 1991). A similar argument could be made for nursing education. Educating health professionals to international standards contributes to the brain drain from disadvantaged nations as well as fostering inappropriate forms of health care.

Development of human resources for health care in Nepal has paralleled the development of the health infrastructure which began in the 1950s. Before 1950, there were an Ayurvedic School and a Civil Medical School for the training of compounders and dressers (Regmi, 1990). There were fewer than a dozen Nepalese doctors prior to the 1950s and they were all foreign educated (Gubhaju, 1991). The Nepal Medical Association was established in 1950 and the first School of Nursing opened in 1956 (Streefland, 1985) when the two first Nepalese women to become nurses returned from their nursing education in India. One of these nurses, Dr. Das, has since earned a PhD from Columbia University in the United States and is currently Director of the Nursing Education Unit of the Institute of Medicine at Tribhuvan University. A mission school of nursing opened in 1959. Both of these nursing schools are in the Kathmandu valley. Nurses were prepared to work primarily in hospitals. Consistent with the epidemiological approach to health care advocated in the first three development plans (1956 to 1970), the development of human resources for the health sector concentrated on the education of certificate level nurses for hospital positions, assistant nurse midwives for health post maternal and child care, health assistants and auxiliary health workers for basic curative care at the health post level, and a cadre of specialized health workers (i.e. specialized in tuberculosis or malaria or leprosy or family planning) to implement the vertical programs. All health personnel were educated under the aegis of the Ministry of Health. Physicians were not educated in Nepal. There were also some Nepalese women who chose to obtain their nursing education in India (some to the baccalaureate level).

Major changes in the thrust of health care and the education of health personnel occurred during the fourth development plan (1970 to 1975) and were consolidated during the fifth development plan (1975 to 1980). The concept of integrated health services was introduced and plans were made to phase out most vertical health programs. The focus changed from an epidemiological approach to a community health approach and the village health worker was introduced. The village health worker receives a three month training course and, while an employee of the health post, is expected to live and work in a village. This category of worker may be male or female (most, if not all, are male) and must have achieved a grade eight education. Preference was given to the health workers from the vertical programs as a major problem of integration was retraining and absorbing the displaced health personnel whose skills were inadequate for the community health approach (Mathema, 1987). Village health workers focus on health promotion activities and are expected to visit homes and collect statistical information (Justice, 1986).

The second major change of the 1970s was transfer of responsibility for the education of some health personnel from the Ministry of Health to the Ministry of Education with the opening of the Institute of Medicine at Tribhuvan

University in 1972 (Dixit and Abeykoon, 1983; World Health Organization, 1984). Basic level health personnel (village health workers) continue to be educated at training centres under the aegis of the Ministry of Health while the education of other personnel are the responsibility of the Institute of Medicine (an exception, which will be discussed later, is the certificate level school of nursing which opened in 1989). By 1983, 11 categories of health personnel were being educated under the aegis of the Institute of Medicine. Assistant nurse midwives (a two year course after grade 8) and community medicine auxiliaries (auxiliary health workers) were classified as lower level health personnel, along with the village health workers whose training remained with the Ministry of Health. The health assistant (for in-charge positions at health posts after a 1.5 year course), the health laboratory technician, the radiography technician, the pharmacy assistant, the ayurvedic assistant and the certificate level nurse (whose 3 year course after grade 10 and an SLC examination pass was the longest education period in this classification) were classified as middle level personnel. New programs added after the transfer of authority to the Institute of Medicine, the bachelor degree level nurse (2 year course after the completion of the certificate level program and work experience) and the medical doctor (4 year course), were developed to provide upper level health care personnel (Dixit & Abeycoon, 1983). Candidates for upper level programs are drawn from middle level practitioners (Dixit & Abeykoon, 1983) but a decision has since been made not to recruit students for medical school from practising nurses as nursing faculty were concerned about the attrition of bright women from nursing and the loss this was to the profession (information from confidential interview data, 1992).

In response to the Declaration of Alma-Ata in 1978 in which Primary Health Care was defined and advocated as the best strategy for achieving the international goal of Health for All by the Year 2000, the sixth development plan (1980 to 1985) introduced the notion of the community health leader, currently known as a community health volunteer, as a mechanism for encouraging community participation (Mathema, 1987; Ministry of Health, 1982; Stone, 1986). This volunteer was to be literate, receive a six week orientation course and work closely with the village health worker. With the addition of the community health leader, the structure of health personnel that currently exists in Nepal was almost complete. Maternal-child health aides, recruited at the village level and receiving three to four months education, are being hired at some health posts as retention of assistant nurse midwives has been difficult. Traditional birth attendants, while not employed in the government health care system, are being upgraded in an effort to reduce maternal mortality rates. Efforts since the early 1980s have focused on expansion of health care personnel in a planned manner to meet health service requirements (Health Learning Materials Project, 1986; Ministry of Health, 1991; Shrestha, 1982; World Health Organization, 1984). Some attention has been directed towards enlisting the assistance of traditional healers in motivating people to change health-related behaviours (Adams, 1988; Parker, 1988; Oswald, 1983; Shrestha & Lediard, 1980; Stapleton, 1989). The Institute of Medicine currently offers undergraduate degrees in medicine, ayurveda, nursing, medical technology and public health as well as a master's degree in public health. All degree programs include content related to community health and management principles (Regmi, 1990). Health personnel staffing patterns are outlined in Figure 2.

By the 1990s, much of the physical structure and human resource planning for implementation of a Primary Health Care approach to health development in Nepal had already

Figure 2

Human Resources for Primary Health Care in Nepal

VILLAGE LEVEL

traditional healers*
traditional birth attendants*
community health leaders**

* may receive some training to upgrade skills or co-operation with government health services

** part of the official health care system, trained under official programs, not a paid government employee

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HEALTH POST LEVEL

1 health assistant (in charge)
2 auxiliary health workers (also called certified medical assistants or CMAs)
2 assistant nurse midwives
6 village health workers

DISTRICT LEVEL

district health officer
public health nurse
health inspector
district hospital staff

ZONE LEVEL

zone hospital staff
(will also be a district administrative centre)

REGIONAL LEVEL

regional medical officer
regional nurse

CENTRAL LEVEL

Ministry of Health Administrative Personnel (division and department heads and planning or supervisory staff)

---

been achieved. Analysis of government documents and professional literature related to health initiatives in Nepal reveals both strengths and weaknesses. Analysis of problems has been astute since at least the early 1980s and comprehensive plans have been formulated to address the issues. Implementation of plans, however, has not always been achieved. Human resource shortcomings, usually centred on the lack of motivation or of management skills, have been suggested as a major reason for the gap between planning and implementation (Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO management Group, 1988; Health Learning Materials Project, 1986; His Majesty's Government of Nepal, 1981; His Majesty's Government of Nepal in cooperation with United Nations Children's Fund, 1982; Shrestha, 1982; World Health Organization, 1984; WHO Regional Office for South-East Asia, 1987). Justice (1987) observed that international pressure guides the planning of health systems in poor countries and that: "To Nepali officials primary health care appeared as an array of demands to be met in exchange for certain resources" (p. 1303). Appropriateness of the planned system was not the major concern of bureaucrats. The acceptance of the principle of an equitably distributed health care system does not mean that it will be accepted at all levels of society or that the political will to support equitable decision-making and implementation of programs exists.

Issues Related to Human Resource Development for Health

Issues confronting health personnel relate to the quantity and quality of different categories of health workers and to the acceptability of their services to the target population. In the Primary Health Care approach to health care, mechanisms for mobilizing people to become motivated and active in planning for health are also important. The entire population becomes a major component of health resource planning. The issue of community participation will be addressed first as it is related to the posting and quality of health care professionals and auxiliaries.

The addition of the community health leader was intended to stimulate community participation and to aid in the creation of local community health committees (Stone, 1986). As health posts are not located in all villages, the community health leader (CHL) and the village health worker (VHW) are the persons responsible for communication about the services available, including motivating people to access them. The health post may be several hours' walk from the village. They are also responsible for health promotion activities. Problems have arisen. "The impact and effectiveness of the CHL is unclear, and the minimal involvement of women in the program has been readily identified as a shortcoming" (Ministry of Health, 1982, p. vii). Inadequate staffing at health posts and the frequent transfer of health post personnel lead to problems in supervising and supporting both CHLs and VHWs. Both categories of community health workers are ill-prepared in community facilitation techniques as their training (six weeks and three months, respectively) is short. The VHW is paid but the CHL is a volunteer. This is a potential source of conflict and dissatisfaction. Few health posts are fully staffed and supplies needed for treatment or prevention may be in short supply for reasons ranging from transportation difficulties, poor management practices (forget to order them until supply is depleted) or corruption (stolen by health post staff or others) (Justice, 1986). It has been suggested that the untrained peon hired to clean and maintain the health post may in fact provide the most consistent and appropriate health care at many health posts (Dixit, 1991; Justice, 1983). Even in fully staffed health posts, there may be few or no staff because of the practice of deputation (being hired for one position but working in another one) or long periods of absence (usually in the Kathmandu valley to lobby for a transfer - ? chakari) (Justice, 1986).

Promotion of community participation in health planning is difficult. Not only must people be mobilized but health care workers must be prepared to respond to community priorities. In a Canadian-sponsored community health project in Mehlkuna, devised to facilitate the development of problem-solving skills in villagers, health was rated in the list of priorities after drinking water, irrigation and schools (Garsonin & Devkota, 1990). Community interest may decrease when their perceived priorities are not addressed in the formal health care system (Stone, 1986; van der Geest, Speckman & Streefland, 1990). Underutilization of services may occur because of cultural barriers (Pearson, 1988; Stone, 1986), interventions which families cannot afford (Nabarro & Chinnock, 1988) and arrogance or other problems in the way interventions are presented (Rifkin, Muller & Bichmann, 1988). Recently, programs have been initiated to upgrade the skills of traditional birth attendants and to incorporate faith healers (Dhamis and Jhankris) into the formal health care system. A project in which the Dhamis and Jhankris were given a four day workshop focusing on family planning, child nutrition and oral rehydration therapy for diarrhoeal disease yielded impressive results. Before the workshop, it was estimated that the 100 participants had motivated approximately 50 people to adopt family planning. Within six months after the workshop, the Dhami-Jhankris had motivated 1,364 people to accept family planning (Shrestha & Lediard, 1980). It was estimated that there were about 1500 paramedicals working in villages and between **four and eight hundred thousand** faith healers in rural Nepal at the time of the study.

As a guide to placing human resource projections in context, Canada and Nepal are compared on a few key variables in Table 3. The population of Canada is less than double that of Nepal. The World Health Organization (1983b) collected health worker statistics in 1980, the year Nepal first developed a formal health manpower planning strategy (Shrestha, 1982). Examination of these statistics suggests that the health services offered and the responsibilities of health professionals in Nepal and Canada must be markedly different. These statistics suggest nothing about distribution of personnel. More than 50% of the doctors in Nepal are in the Kathmandu valley (Maskey, 1991). There are 71 certificate or higher level nurses for every 100 doctors (Maskey, 1991). Statistics reported regarding the number of public health nurses are contradictory. One source reports that only 21 posts have been sanctioned for public health nurses in the Ministry of Health (up from 8 in 1985) and 21 are filled (up from 7 in 1985) (Ministry of Health, Nepal, 1991). The same source, but updated a few months later, reported higher numbers (Table 4) but differentiated between levels. Most of the filled posts are in the Kathmandu valley or other major urban centres and most districts have no public health nurse coverage.

Regmi (1990) suggests that health manpower requirements in Nepal exceed production and that a serious imbalance exists among categories of health personnel. Attention still needs to be paid to expansion of the health system infrastructure. Motivation among administrative and other health care personnel must be fostered in order to promote increased productivity, teamwork, interdisciplinary cooperation and adequate resource mobilization. Teaching facilities and methods need upgrading. Finally, there is a need for existing health workers to receive formal orientation to the goals and methods of Primary Health Care.

The report of the second health manpower planning

Table 3

Comparison of Nepal and Canada on Health Care Statistics

VARIABLE	NEPAL	CANADA
1986-87 (WHO, 1992)		
GNP per capita	$160US	$15,190US
% spent on health	0.8%	1.4%
$/capita spent on health	$1	$207
Health Personnel - 1980 figures (WHO, 1983b)		
Physicians	487	42,238
Certificate or Higher Nurses	433	140,000
Assistant Nurses	1,433	41,000
Medical Assistants	2,338	
Pharmacists	1	15,709
Dentists	17	9,900
Health Care Facilities - 1980 figures (WHO, 1983b)		
population/hospital bed	5,477	102

The population of Canada is less than double that of Nepal.

exercise (Shrestha, 1982) identifies issues which my interviews with nurses in 1991-92 also revealed. Administrative and human resource production issues were discussed. Four areas of concern related to the production of health care workers:

(i) inadequate numbers are being produced,

(ii) local training of some categories of health workers may enhance retention in rural areas,

(iii) high attrition rates from Institute of Medicine students, and

(iv) lack of coordination between service requirements and health personnel produced leading to difficulty in providing employment opportunities to all new graduates (education targets are met but infrastructure expansion is not).

Administrative issues which were identified included:

(i) delays in sanctioning and filling posts,

(ii) inappropriate postings and unrealistic job descriptions (mismatches of personnel to jobs),

(iii) reluctance to work in rural areas,

(iv) regional inequities,

(v) inefficient staffing patterns and organization,

(vi) inconsistent application of rules, regulations and policies (for postings, transfer, promotion and educational opportunities),

(vii) no reserve pools of personnel,

(viii) absence of staff from positions for which they have been hired leaving those positions filled but not manned (due to deputation or educational leave), and

(ix) problems integrating staff from vertical projects.

Inconsistent application of rules, regulations and policies may be related to the practices of afno mannche and chakari in which a patronage system in decision-making is exercised. While the literature suggests that there is a policy of mandatory medical service requiring doctors to practise in rural postings for two years after graduation, physicians with "source force" (family connections) have been able to bypass this requirement. These physicians with class connections have often bypassed the experience as middle level health workers by seeking medical education outside of Nepal. There are economic repercussions to rural postings as government salaries are low and opportunities for private practice are few because of scattered populations and poverty in rural areas. Even after the mandatory two year rural posting, physicians lacking "source force" have difficulty acquiring urban postings. Thus a division within the medical profession has arisen. "There is a battle going on between two groups of doctors: those with source force who are pressing for greater privatization, and those who lack source force and want the state to assure greater equity in the profession" (Weiner, 1989, p. 674). Reform is difficult because "the advocates are the weaker members of the profession, whereas those who wish to maintain the present system of patrimony are closer to the centres of power" (p. 674).

While development of the human resources for Primary Health Care has received much government attention since 1980, significant problems remain. The majority of the population in Nepal still has minimal access to the services of health professionals or auxiliaries. Mortality and morbidity rates indicate progress but still fall far below targets. Lack of leadership and motivation in the health sector appear to be significant issues. It is time to examine the development of nursing in Nepal.

The Development of Nursing in Nepal

The development of the nursing profession in Nepal can be traced to the first two Nepalese women to train as nurses in India in the 1950s. Both returned to Nepal in 1956, the year the first school of nursing opened in Kathmandu. A second school of nursing (mission run) opened in Patan (also in the Kathmandu Valley) in 1959. Graduates of these nursing programs were expected to take positions in the expanding hospital and clinic system. They were not expected to participate in the public health initiatives at the health post level, although they were often involved in the education of the assistant nurse midwife. By 1991-92, when data for this study were collected, there were seven certificate level nursing programs, one post-basic baccalaureate program, plans to admit the first master's in nursing student in the near future and two training centres (reduced from the three initiated in the 1960s which at one time had been increased to five) for assistant nurse midwives. The Division of Nursing forms one of 12 administrative units within the Ministry of Health. The upgrading of traditional birth attendants (TBAs) is also under the aegis of nursing. While I was able to access some literature on Primary Health Care in Nepal prior to travelling there for data collection, there was little mention of nursing involvement. Other than in the nursing literature (Anderson, Nichol, Shresthra & Singh, 1988; Das, 1986; Sharma & Ross, 1990; Tamsang & Anderson, 1990), mention of nursing involvement in Primary Health Care in Nepal in the health-related literature focuses on the assistant nurse midwife.

Assistant Nurse Midwives

In 1962 the first assistant nurse midwife training centre was opened. The category of assistant nurse midwife was developed in response to a need for maternity and child care to be offered at the level of rural health posts. There was never the intention for assistant nurse midwives to work in hospitals. Two issues stimulated the promotion of this category of health worker: other health post and village level workers tend to be male and rural women in Nepal are unlikely to seek assistance from male health workers and would never allow a male attendant at childbirth (Justice, 1984; Reissland & Burghart, 1989); and increasing education and employment among women was perceived as a mechanism for increasing the status of women and for attracting international funding (Justice, 1984). In reality, most women still prefer to be attended at delivery by female relatives who are also mothers - "women of proven fertility and personally experienced in childbirth" (Reissland & Burghart, 1989, p. 44). By 1972, Nepal had 241 assistant nurse midwives (World Health Organization, 1984). By 1980, after the shift to a community health approach to health and the movement away from vertical health services to an integrated approach, Nepal had 1,049 assistant nurse midwives, with 60% of them assigned to rural health posts. Being assigned to a rural health post, however, does not translate into working at a rural health post. In many cases, the salary was collected but the actual work done was in a district hospital where funds for employment of nurses were scarce but the need for nursing staff existed (Justice, 1984). "According to government reports, all ANM positions are filled on paper; however, official estimates are that only 30% of the positions actually have ANMs working in them at one time" (Justice, 1984, p. 194).

A 1984 report on nursing manpower in Nepal stated that, while 2,261 ANMs would be needed by the end of 1985, only 1,505 (66.5%) posts had been created. By June of 1984, 1,975 ANMs had been trained in Nepal (World Health Organization, 1984). By 1987, there were 1,808 ANMs employed in the government system and a target of 5,000 ANMs for the year 2000 had been set (Basic Minimum Needs and HFA/2000 Steering Committee and HMG/WHO Management Group, 1988). As of December of 1991, there were positions for ANMs both in hospitals and in health posts. Of 473 positions in hospitals, 420 were filled. Of 1,548 positions at health posts, 862 were filled (Ministry of Health, Nepal, 1991). The practices of deputation and of considering positions filled when incumbents are on study leave mean that filled positions are not always manned positions. There are no accurate statistics on manned positions although attention has been directed to the problem in recent years.

Reasons given by ANMs working on deputation in Kathmandu for not being at their assigned positions relate to family obligations, personal aspirations and conditions at the area of posting. Husbands are in Kathmandu and parents are old and in need of care. ANMs are studying in Kathmandu. Postings are too isolated, living facilities are inadequate (when available) and the health posts are insufficiently supplied (World Health Organization, 1984). Justice's research (1984) provides additional insight. Culturally, it is socially unacceptable for girls to live alone in Nepal. In addition, low female literacy rates, particularly in rural areas, mean that most ANMs are from urban areas. Their families are unaware that postings to rural areas are to be expected after graduation. Permission to attend the course was often granted with the view to achievement of a salaried income and the potential for marrying up. In reality, health posts are often in isolated villages, several days' walk from the nearest district centre or motorable road. Housing may not be readily available and may have to be sought in the community. They may be the only women working at the health post and there have been reports of health assistants expecting them to act as personal maids. Generally, women only seek childbirth assistance when complications, for which ANMs lack preparation, occur. Supervision is supposed to be provided by the district public health nurse but only 8 of 75 districts had public health nurses at the time of Justice's study (the situation has not improved). When interviewed, one public health nurse stated that in her two year posting she had only visited each of the 11 health posts under her supervision once. Reasons given were lack of transportation and fears of being robbed. Even the stated plan of ANMs seeking involvement in the upgrading of TBAs (dais) is questionable as in many areas of Nepal there are no dais and it is estimated that 90% of women rely solely on female relatives during childbirth. In spite of these problems being known to planners, the ANM program was expanded in 1979.

By the 1990s, problems in attracting and retaining ANMs at the health post level were evident. Increased expansion of this category of worker, however, is planned. Positions for ANMs have been sanctioned at hospitals, although their educational preparation is inadequate for the demands of the job. Additional training to prepare senior ANMs for hospital work has been available sporadically. Recently, entry requirements for ANM training centres have been increased from grade 8 to grade 10. Many ANMs have upgraded their education and applied to certificate level nursing programs as there are no possibilities for career progression as ANMs. Increasing the number of ANMs contradicts the recommendation of a 1986 health planning exercise which began with an assertion that ANMs were to be phased out and replaced by locally recruited and trained health workers. The rationale given was the difficulties encountered by ANMs in trying to practice what they had been taught because of inadequate management and supervision given that few districts had public health nurses. ANMs often became assistants to the health assistants in charge of health posts rather than independent practitioners responsible for maternal and child care. It was recommended that current ANMs with SLC examination passes be upgraded to certificate level nurses and that the remainder of ANMs be downgraded to maternal child health workers (Health Learning Materials Project, 1986). This recommendation appears to have been rejected as the target of training 5,000 ANMs by the year 2000 remains.

Nurses

The growth of professional nursing (certificate level or higher) in Nepal has been slow. While two schools of nursing were opened in the Kathmandu Valley in the 1950s, their enrolment was small and no further nursing education facilities were opened until the 1980s. There are conflicting statistics as to how many nurses were produced between 1960 (first graduating class) and 1972 when responsibility for nursing education moved to the Institute of Medicine at Tribhuvan University. Figures released by the Nursing Education Unit at Tribhuvan University state that there were 147 graduates from the government school of nursing between 1960 and 1972 and 71 graduates from the mission school of nursing between 1963 and 1972 (information provided by Dr. Das, Director of the Nursing Education Unit at the Institute of Medicine). Averaged over the time each school had been open, there were approximately 11 certificate level nursing graduates a year in the government system and 7 in the mission system. These statistics conflict with those released in a 1984 report on nursing manpower in Nepal (World Health Organization, 1984) where it is reported that 376 certificate level nurses graduated between 1960 and 1972. In either case, the number of graduates was small. It is not surprising that there are fewer nurses than doctors in Nepal, although recent expansion in nursing education will change the balance within the next few years. During this time period, all Nepalese doctors were foreign trained. There were also some Nepalese women going to India for nursing education.

Interview data revealed that it was very difficult to recruit sufficient nursing students in Nepal during the early years and recruitment outside Nepal was often an option. Only female students were accepted and recruitment difficulties were partly related to the low educational achievement of girls in Nepal. Female literacy was 1.8% in 1961 and 3.7% in 1971.

The transfer of responsibility for the education of all except basic level health personnel from the Ministry of Health to the Ministry of Education in 1972 heralded some changes in nursing education. Both schools of nursing came under the aegis of the Institute of Medicine. Faculty received university appointments at Tribhuvan University. The potential for increased physician control of nursing was set. No nurse has yet been appointed Dean, although the Associate Dean in charge of administration during the period of data collection for this study was a nurse. She has since been replaced by a doctor.

It was in the 1970s that the post-basic baccalaureate nursing program was planned and initiated. The first class was accepted in 1976. Certificate level nursing education did not change substantially in the 1970s and remained primarily oriented to preparing nurses to fill positions in hospitals. The situation changed substantially in the 1980s. The first manpower planning exercise for health personnel was held in 1980 (Shrestha, 1982) and concern was expressed regarding the critical shortage of nurses. Nursing campuses were opened at Biratnagar (1982), Pokhara (1984-85), Birganj (1986-87), Nepalgunj (1987) and Bir Hospital (1989) (World Health Organization, 1984; WHO Regional Office for SouthEast Asia, 1987; interview data). Enrolment at the two existing campuses, Maharajgunj and Lalitpur, was expanded. Bir Hospital Nursing Campus follows the national curriculum but is under the aegis of the Ministry of Health as faculty at the Institute of Medicine felt unable to handle the amount of expansion decreed by the development plans. All other nursing campuses are under the aegis of the Institute of Medicine and a common curriculum is taught. Three nursing campuses (Maharajgung, Lalitpur and Bir Hospital) are in the Kathmandu Valley, one is in the central hills (Pokhara) and three are in the Terai in border towns with India (Biratnagar - east, Birganj - central, Nepalgunj - west)(see Appendix 11 for map). It is hoped that recruitment of students may be regionalized and thus decrease the centralization of resources due to everyone wanting to work in Kathmandu. By 1991, 1,824 certificate level nurses had been prepared in Nepal (Dr. Das, Nursing Education Unit, Institute of Medicine). At the time of data collection for this study, there were 186 third year student nurses in Nepal who were to graduate in 1992. There were also 442 first and second year students. Expansion of nursing education has been rapid and there is a concern that expansion of health services will not keep pace, leading to an inability to absorb all new graduates into the system.

Expansion of nursing campuses and student intakes was not the only major change in nursing education in the 1980s. "Since the efforts made in Nepal to improve health care delivery had little impact, it was decided to introduce the primary health care concept in nursing education so that nurses could reach and care for the people at all levels" (Das, 1986, p. 87). Thus: "In 1987 nurse educators in Nepal implemented a revised certificate nursing curriculum oriented toward primary health care (PHC) and a bachelor of community health nursing (CHN) curriculum with emphasis on leadership for PHC" (Tamsang & Anderson, 1990, P. 345). Major problems confronted in implementing the curriculum change have revolved around the lack of appropriate preparation of faculty, the need to expand sites for clinical experiences for students and the need to motivate graduates for employment in rural areas (Anderson, Nichol, Shrestha & Singh, 1988; Tamsang & Anderson, 1990).

The government postings for nurses are regulated at the Division of Nursing in the Ministry of Health. Data released to me in March of 1992 (updated as of December of 1991) indicate that all new graduate nurses in 1992 will not be absorbed into the government system. Table 4 presents the hospital and public health positions currently available for professional level nurses. No information on deputation figures was available. Government positions, however, do not provide the whole picture of employment opportunities for nurses in Nepal. Urban centres have private hospitals and clinics. The United Mission to Nepal (UMN) also has health care facilities as do numerous other non-governmental organizations (NGOs). In these agencies, nurses have been able to work in expanded roles.

There are a few other pieces of information that are relevant to assessment of the current level of development of the nursing profession in Nepal. The Chief of the Division of Nursing has been appointed to the Joint Health Management Group of the World Health Organization and His Majesty's Government of Nepal. This appointment provides a mechanism for nursing input at the policy level (WHO Regional Office for Southeast Asia, 1987). There are two WHO nursing advisors in Nepal - one in nursing education and one in nursing service. Faculty at nursing campuses are mostly Nepali but UMN nurses provide support as well as nurses from international volunteer agencies (Peace Corps, Danish Volunteer Service, VSO [British]). The Nepal Nurses Association is being revitalized using financial and technical support from the Norwegian Nurses Association and the Canadian Nurses Association.

Issues Confronting the Nursing Profession in Nepal

The issues confronting the nursing profession in Nepal,

Table 4

Nursing Personnel in Government Health Service Positions in 1991

Hospital	# of positions	filled	vacant
Gazetted First Class	3 (Matron)	3	0
Deputy Secretary	7 (Matron)	6	1
Assistant Secretary	10 (Assistant Matron)	10	0
Sisters	63	60	3
Staff Nurses*	330	267	63
Assistant Nurse Midwives	473	420	53
- no data on deputation			

Public Health	# of positions	filled	vacant
Gazetted Second Class	5 (Regional Nurse)	3	2
Assistant Secretary	1	1	0
Senior PHN (Public Health Nurse)	17 (includes Division of Nursing Staff)	15	2
Public Health Nurses (some districts have more than one PHN - less than 16 of 75 districts have PHNs)	16	16	0
Assistant Nurse Midwives	1548	862	686
- no data on deputation			

From: Ministry of Health, Nepal. (1991). Health Information Bulletin: Volume 7. Kathmandu: His Majesty's Government.

* 186 certificate level nurses were expected to graduate in mid-1992.

as analyzed and presented in three government/WHO documents (Health Learning Materials Project, 1986; World Health Organization, 1984; WHO Regional Office for South-East Asia, 1987), parallel administrative, management and personnel issues which have already been mentioned in discussion of issues related to human resource development for health. Targets for expansion in nursing education are being met but expansion of health services and sanctioned positions do not always keep pace. It takes 29 steps to create a position in the Ministry of Health (World Health Organization, 1984). The bureaucracy has several levels of decision-making and it is sometimes difficult to detect where the actual authority and responsibility lie. Lines of authority are unclear. Rules, regulations and policies for transfer and deputation are confusing and are often manipulated or not followed. There are many ways by which decisions made within the Division of Nursing may be influenced or subverted and staffing decisions often reflect personal rather than institutional needs (Health Learning Materials Project, 1986).

It is difficult to get nurses willing to work in remote areas and consequently many nurses holding positions in district hospitals are working on deputation at hospitals in Kathmandu. Working in remote areas is promoted by offering a point system for promotion whereby service in rural settings is worth more points but this incentive is insufficient. Deputation allows urban hospitals to be more fully staffed than their allocated positions would permit and is useful as current sanctioned staffing patterns are inadequate for coverage of all shifts. Inappropriate staffing patterns include the tendency to place all senior nurses on the day shift and to allocate days off in relation to personal rather than institutional needs. Supervision, evaluation and inservice education are lacking. There are insufficient opportunities for promotion. (Health Learning Materials

Project, 1986). There is a serious problem with positions in public health. For public health nurses to be promoted usually requires that they move to hospital positions because of the scarcity of senior community health positions open to them (WHO Regional Office for South-East Asia, 1987).

Three areas of concern were identified at a 1984 seminar devoted to nursing personnel issues: bad working conditions for nurses, low competence and low morale (World Health Organization, 1984). Problems related to working conditions included low pay, understaffing leading to overwork, no places to change at clinical settings, no lockers in which to leave purses and other personal effects, inadequate transportation, no family quarters (or hostel accommodation which was in need of repair) and no canteen facilities. As late as 1987, there were suggestions in the literature that cooperation with agencies such as UNICEF was needed to improve the water supply and sanitation facilities in health care institutions. Basic materials needed to give safe nursing care, such as soap and water, are often in short supply or unavailable (WHO Regional Office for South-East Asia, 1987). Low competence was attributed to lack of understanding of nursing procedures. Lack of supervision and inservice education contribute to the problem as does the use of ANMs for staff nurse positions. Signs of low morale include lack of compliance with instructions, absenteeism without prior leave, quarrels with senior staff and lack of motivation to correct past mistakes. These issues will be more fully explored in the discussion of interview data.

Nurses have been lost to government service via transfers to the private sector, entry into non-nursing positions and engagement in "international marriage". They have contributed to the brain drain by accepting nursing positions abroad (Health Learning Materials Project, 1986).

Reflections on the Development of Human Resources for Primary Health Care in Nepal

Development of human resources for health in Nepal has been congruent with the directions pursued in successive health plans. Most categories of personnel were determined in the 1950s and 1960s and educational facilities were established by the Ministry of Health in conjunction with missions and other NGOs. International aid in terms of technical advice and financial resources was accepted. Responsibility for most human resource development for health care shifted to the Ministry of Education in 1972. The Primary Health Care philosophy was accepted and has guided decision-making since the Sixth Development Plan (1980-85). While gains have been achieved in lowering mortality and morbidity rates, there is still a long way to go. Professional nurses have been left out of government planning for community health in terms of any meaningful role and remain employed mostly in traditional roles in hospitals. This relegation to a mostly traditional role leaves nurses, one of the most highly educated groups of health professionals in Nepal, in one of the least autonomous positions in the health care system. In response, nurses have developed both certificate level and baccalaureate level curricula with strong orientations to nursing involvement and leadership in Primary Health Care.

CHAPTER 6: NURSING INITIATIVES FOR PRIMARY HEALTH CARE IN NEPAL

Nurses in Nepal appear to be taking advantage of current inadequacies in the health care system, as well as the WHO suggestion that nurses could become leaders in Primary Health Care, to carve a new niche for themselves. Leadership is being provided by the new curricula for certificate level nursing students (implemented in 1987) and for bachelor level nursing students (implemented in 1989). In addition, mission and NGO health and development agencies are employing Nepalese nurses in expanded and management roles. The current president of the Nursing Association of Nepal, Meena Shakya, was employed by an NGO for three years in a planning and administrative capacity and is convinced that Nepalese nurses have the attitudes, knowledge and skills required in order to become leaders in Primary Health Care initiatives (interview data). Ms. Shakya is currently a faculty member at Maharajgunj Nursing Campus.

In Leadership in Nursing for Health for All: A Challenge and Strategy for Action (WHO & BLAT Centre for Health & Medical Education, 1987), the meaning of Primary Health Care for nurses is outlined, issues regarding the nursing "culture" are discussed and the conclusion that nurses have a responsibility to lead the change is reached. In summary, Primary Health Care means revolution and decentralization within health care systems. As nurses comprise 50% of the world's health care resources, they are in a good position to become change agents in the transformation process. To do so, nurses need political awareness. Valerie Collett, a UMN nurse currently teaching in Nepal, compared the process through which nurses must go to Freiere's concept of "conscientization" in her master's thesis on the role of nurses in Primary Health Care (Collett, 1989). Nurses also need support from governments, nursing associations and WHO.

The predominant nursing culture fosters subordination without influence and obligation without power. "Such an ethos militates against the emergence of positive initiative" (WHO & BLAT centre for Health and Medical Education, 1987, p. 5). For Primary Health Care to work, community attitudes need to shift to an ethos promoting healthy living and away from a perception of health care being of value only when curative services are stressed. Nurses need to learn to share their knowledge and skill and to learn to delegate responsibility for their health back to the people. People have to be mobilized. Values inherent in the Primary Health Care philosophy are self-reliance, social justice, wise use of resources, social and quality control of the health infrastructure and a willingness to take risks. Nursing leaders are needed who have the skills required to mobilize others, who are able to motivate and provide direction, who feel strongly about issues and who are thinkers as well as doers. These nurses must recognize the connections between literacy, living standards and other development initiatives as integral to improvement of the health status of individuals and populations. Thus a nurse with clear understanding, capability, confidence, capacity to motivate, commitment and comprehension of intersectoral issues is needed. Quality and not just quantity of nursing personnel must receive focus. As a profession, nurses need to be sensitized, organized, politicized and mobilized. Nurses tend to be good communicators and their special skills need to be recognized. Opportunities to exercise leadership must be provided both for graduate nurses and for students (WHO & BLAT Centre for Health and Education, 1987).

How can nursing leadership in Primary Health Care be promoted? Nurses need to develop traits which challenge and negate female stereotypes. Legislative changes, increased education/service collaboration and experience in positions from which nurses may exercise power are needed. Nurses need control of budgets and they need to be able to discuss broad issues related to health and development. Finally, nurses need public recognition of their value and they need to exert power at the policy level (WHO & BLAT Centre for Health and Medical Education, 1987).

Nursing initiatives for Primary Health Care in Nepal were examined from three directions in this research. The new curricula were examined in comparison with the curricula they replaced in order to capture how the change in nursing role is being conceptualized. Questionnaires were completed by faculty and students. Faculty and other nursing leaders were interviewed. Findings from the review of curricula and part of the questionnaire data are presented in this chapter. Faculty and student profiles and interview findings will be presented in following chapters.

Curriculum for Certificate Level Nursing Students

Changes in the certificate level nursing curriculum have reflected changes in the health care system in Nepal. Thus the goal of the 1970 curriculum was the preparation of nurses to practice nursing in the hospital and the community (Certificate Level Nursing Curriculum, 1970) whereas the wording of the 1980 curriculum was more reflective of the changes in health care in the 1970s. The aim of the curriculum became the education of nurses to provide comprehensive nursing care in an integrated health service setting with attention directed to population dynamics (emerging as a priority concern in Nepal) and to both the preventative and curative aspects of nursing (Certificate Level Nursing Curriculum, 1980). For admission, a woman had to be single or widowed, between 16 to 25 years old, Nepali and have earned an SLC pass. A parent or guardian had to endorse a bond requiring five years of nursing service after graduation. The training stipend was to be repaid if the student failed to complete the three and a half year training without having a valid reason. Students were selected after an interview and a pre-entrance examination. Emphasis was placed on hospital nursing although some community health and midwifery content were included. As Dr. Das, Director of the Nursing Education Unit at the Institute of Medicine, stated: "The nursing campuses operated with the same curriculum for many years. Periodically a course would be revised, but the curriculum as a whole was due for revision" (Health Learning Materials Project, 1987, before numbered pages). With the help of the World Health Organization (a participant in all nursing education efforts since 1956) a new curriculum, with Primary Health Care as the central concept, was developed.

The new curriculum was implemented in 1987. In his foreword to the new curriculum, Dr. Upadhyay, Dean of the Institute of Medicine at the time, said:

> The nursing educators have responded to both the international nursing standards and the health priorities of Nepal by developing a primary health care approach in this revised curriculum....The broadening emphasis in the curriculum ensures that nurses are not only hospital-centred, but also have the knowledge and skill to practice nursing in the community. This is a necessary and welcome step. (Health Learning Materials Project, 1987, before numbered pages)

R. Charan Shrestha, Chief of the Division of Nursing in the Ministry of Health at the time, made the following comment:

> The original nurse training with an emphasis on individual custodial patient care in the hospital setting has evolved into a more holistic community approach....The implementation of primary health care in Nepal is a complex problem in which nurses have an opportunity to play a major role in planning and providing leadership....The curriculum prepares nurses to function in a variety of roles, not only the traditional role. Therefore, working opportunities for nurses must expand into the community, which will result in an

> expansion of the profession with greater challenges to nurses and greater contributions to the people of Nepal. (Health Learning Materials Project, 1987, before numbered pages)

Dr. Das, Director of the Nursing Education Unit, stated in her foreword to the curriculum: "The teaching/learning activities are much more student-centred, with students playing an active role in the learning process" (Health Learning Materials Project, 1987, before numbered pages). All of these comments suggest that nursing educators and leaders and medical educators were aware that the intent was to prepare nurses for roles not yet existing within the health care system.

Questionnaire responses reveal the changes in entrance requirements. There were responses from male students, married students and students over the age of 25 years. The ten objectives of the program provide most of the information needed to assess how nurse educators perceived the role of the nurse in Primary Heath Care. Verbatim, these objectives are:

> Upon completion of the programme the graduate will:
>
> 1. Utilize a sound knowledge base in giving care to well and sick individuals, families and communities.
>
> 2. Perform preventive and therapeutic measures directed toward promotion, maintenance and restoration of health.
>
> 3. Utilize communication skills effectively with individuals and groups in a variety of settings.
>
> 4. Utilize the nursing process in providing and improving health care.
>
> 5. Assume leadership for planning, directing and evaluating care given by health workers.
>
> 6. Teach and supervise individuals, families and groups including health care workers.
>
> 7. Collaborate with multisectoral groups to develop a healthful environment, including safe drinking water,

> sanitation and other basic needs of the community.
>
> 8. Mobilize the community to participate in the activities of the village health post.
>
> 9. Demonstrate a positive attitude and respect for cultural values in working to meet needs and solve problems.
>
> 10. Continue to seek new knowledge for personal and professional growth.
>
> These overall objectives are used in each year to create specific objectives which guide the learning experiences from simple to complex. (Health Learning Materials Project, 1987, p. 6)

These objectives seem to provide a role for nurses within the existing health care system while providing scope for enhanced community involvement. Objective 8, regarding mobilizing community participation at the health post, appears consistent with other government literature on community involvement but is a long way from the Primary Health Care ideal of facilitating communities in their own development of priorities for meeting their basic needs. Empowering people to meet their own needs is the most politically sensitive aspect of Primary Health Care.

In the first year of the program, which is oriented to fundamentals of nursing and basic science courses as well as introduction to community health, students have 21 weeks of clinical experience in the hospital and 8 weeks in the community. In the second year of the program, they have 17 weeks of midwifery experience in the hospital and 4 weeks of pediatric hospital experience as well as 8 weeks of community health nursing experience. The entire second year is devoted to maternal and child care, a stated priority of the health care system. The third (final) year of the program focuses on adult nursing (25 weeks in the hospital) and leadership and management (4 weeks in the hospital and 4 weeks at a health post) (Health Learning Materials Project, 1987). The community experience is new in this curriculum as is a greater focus on health assessment of individuals, families, groups and communities.

Examination of what students are expected to achieve during their community health experiences reveals the roles for which nurses are being prepared. The first year practicum focuses on community diagnosis. After being provided with an orientation to the community and to available resource persons, students are required to collect health data from five families. One of these families is then chosen to receive a home visit during which the health practices of the family are assessed. In collaboration with the family, a community action must be initiated to address a priority health issue. Students have assisted families in building latrines and making gardens as part of the community action portion of the community experience. In addition, first year student nurses must initiate two teaching sessions, one at the community level and one at the family level. Mostly, students choose to do health teaching sessions but they have also been active in taking families to health posts to immunize their children and in motivating families to enrol their children in school. Refuse disposal is another area in which students have chosen to direct attention (interview data).

The second year community health experience includes 4 weeks in clinics (family planning, antenatal, etc.) and four weeks in the field. The field experience focuses on maternal and child care. Students are expected to select 5 women for monitoring antenatal care, 5 families for postnatal and follow up care and one woman for management of a home delivery. Generally, it is not possible for each student to manage a home birth as the mother may live a one or two hour walk from where the student is staying. A group of eight students and one faculty member stay in each field site at a time. Therefore, an attempt is made to have all students observe a home birth with either a student or the assistant nurse midwife from the health post managing the birth (interview data).

While the curriculum suggests that students get four weeks of management experience in the community during the third year of the program, I was given to understand that only three weeks have been implemented (interview data). One week is spent observing administrative practices in places such as a district office, the division of nursing, a mission hospital or a nursing campus. Two weeks are spent at a health post. Focus is on management issues. The job description for the person in charge is examined, problems are discussed and health committee meetings are attended. The examination of patients is observed but not performed by student nurses. The students do perform dressings and give injections and other treatments. They are not expected to do independent examinations, diagnose illness or prescribe treatment. They are expected to provide health teaching and, if there is no assistant nurse midwife, may assume responsibility for maternal and child care under the supervision of the faculty member. The student nurses are also expected to provide some inservice education for health post staff (interview data).

The role that student nurses are assuming during the first year of their program is one which is not currently filled by any health worker. Nurses are being educated to assume a leadership role in health promotion activities at the village level. The village level health workers (village health worker and community health leader) have insufficient training to make the necessary changes although, if highly motivated and adequately supervised, they could do part of what the nurses are trying to achieve. The second year experience parallels the role of the assistant nurse midwife. This is essential experience for certificate level nurses hoping to work as public health nurses as the PHN at the district level is responsible for supervision of ANMs at the health post level. There are no government postings which allow graduate nurses equivalent experiences. While certificate level nurses receive some management experience (by observation) at the health post level, they are not expected to take charge or to diagnose and treat clients independently. There are countries where nurses have assumed these roles in Primary Health Care. This issue will be explored more fully when the interview data are discussed.

Student nurses all receive a copy of the curriculum in which the roles of the nurse are delineated as teacher, supervisor, facilitator, communicator, change agent, motivator, problem-solver, planner, care provider, evaluator and advisor (Health Learning Materials Project, 1987). Faculty orientation was essential for implementation of the curriculum as faculty are teaching in areas not familiar to them. In addition, one strategy to strengthen implementation of the curriculum has been faculty development of textbooks relevant to the Nepalese context (interview data). In addition, student nurses are encouraged to assume a health promotion and teaching role in their care of hospitalized patients. Applicants for the certificate level nursing program are no longer interviewed or required to take a pre-entrance admission examination (interview data).

Curriculum for Bachelor Level Nursing Students

Two intakes of 15 students each were admitted to the first post-basic bachelor's level program in nursing. When this program was initiated in 1976, there were one government school of nursing in Nepal (and one mission school) and five assistant nurse midwife campuses. With the exception of missions, only one campus had a trained nurse midwife teacher. Thus development of qualified midwifery teachers for both basic nursing education and for professional development of existing nursing personnel was perceived as urgent. The stated goal was the education of a qualified nurse who would be experienced in midwifery but who would also possess the knowledge and skill to critically examine and define acceptable standards in postings as clinical tutors (for students) or ward sisters (for staff). While this program did not include a course on general social development or on development issues specific to Nepal, there was a course oriented towards the education of health personnel for the Nepalese context. This course focused on the development of nursing personnel (BN Program Midwifery, 1978). This program was two and a half years in length and was open to certificate level graduate nurses (Health Learning Materials Project, 1989).

The second bachelor level nursing program replaced the first one in 1981. Oriented towards community health, this program was two years in length. Two intakes (a total of 29 students) completed the program. The philosophy of the curriculum mentions the impact nurses could have on women as being one reason for promotion of the nursing profession in Nepal. Impetus for the program came from the belief that the major health problems in Nepal related to maternal and infant mortality and morbidity, including infectious diseases and their complications. These health problems are all related to women's responsibilities in the home, including hygienic practices and nutrition. In addition, there was a long-term plan to educate the 75 public health nurses (plus 10% to cover sickness, retirement, etc.) who would be needed to implement the plan of a public health nurse in the district office of all districts in Nepal. There were already a few public health nurses in Nepal who were foreign educated and were employed in the vertical programs. At the time this curriculum was implemented, figures from the Ministry of Health indicated that only 14% of professional level nurses were working in rural areas (defined as those with hospitals of 15 to 25 beds) whereas

78% of assistant nurse midwives were in rural areas (but not necessarily at health posts). Of 66 trainers in ANM programs, less than 10% had any public health training and fewer than that had any community health experience. There was also a beginning demand to incorporate increased community health content into the certificate level nursing program and faculty with the relevant knowledge and skills were needed (BN Curriculum Community Health Nursing, 1981).

The stated goal of the program was the preparation of a nurse who would be qualified to supervise ANMs, provide assistance to personnel in charge of health posts (particularly for issues related to ANM responsibilities), represent nursing responsibilities as part of the district health office team, and act as faculty for ANM training or certificate level nursing education. Courses offered pertained to development of the health services of Nepal, maternal health, child health, community health and health research (including epidemiology and social sciences as applied to nursing). Students could choose to pursue either a teaching or an administrative elective (BN Curriculum Community Health Nursing, 1981).

Two new programs were introduced in 1984 to replace the BN in Community Health Nursing. In 1984, 1985 and 1987 students were admitted to a program specializing in adult nursing. The 47 graduates received a program oriented to the preparation of nurses who would be:

(i) clinical practitioners who can guide and work with staff nurses,

(ii) qualified to act as faculty,

(iii) able to assume leadership positions in hospitals, and

(iv) able to prepare nurses to conduct simple studies in the clinical and teaching areas of adult nursing.

The curriculum included a course devoted to social sciences applied to nursing (as did the pediatric curriculum which was implemented at the same time) and a course on economics and development as related to health (BN Curriculum: Adult Nursing, 1984). These courses appear to be attempts at "conscientization" of nurses in Nepal beyond the confines of traditional nursing practice.

In 1984, 1985 and 1986 students were admitted to a program specializing in pediatric nursing (Health Learning Materials Project, 1989). The 45 graduates received a program focusing on in-depth knowledge of the nursing process, clinical supervision, child assessment, management, common life-threatening diseases, motivation of students and communication skills. The content for this program was developed from responses to a questionnaire regarding the child health priorities in Nepal which was administered to nursing and medical superintendents of all hospitals, district/zonal medical officers, senior sisters and nursing staff, administrators at the Ministry of Health, program chiefs and public health nurses. For the first time in the nursing curricula, the goal of preparing nurses for Primary Health Care and the goal of Health For All by the year 2000 were mentioned. Students admitted to this program were required to have at least three years of clinical or teaching experience. They were being prepared to work as:

(i) child health nurse practitioners in hospital, clinic, health post and community,

(ii) nursing faculty, or

(iii) as a full member of the district health team in initiating, planning, implementing and evaluating nursing and health care programs.

They were also being prepared to provide leadership as administrators in health care settings, as supervisors and co-ordinators of continuing education activities and as researchers with basic skills to develop studies to improve nursing practice (BN Curriculum Pediatric Nursing, 1984). The conceptualization of potential nursing leadership and participation in health care in Nepal appears to be changing in the content and wording of both the pediatric and the adult nursing curricula. Leadership beyond the sphere of nursing is being suggested.

The current bachelor's level curriculum was implemented in 1989. Rather than educating nurses in specialized fields of nursing, a generalist curriculum was developed with two tracks, hospital nursing and community nursing, being offered. Students receive common core courses in teaching, management and research. As stated in the curriculum:

> The overall aim of the post basic bachelor of nursing programme is to prepare nurses who can use independent judgement in making nursing decisions, function in leadership positions in the provision of health care in the hospital and community, teach in nursing and other health programmes and conduct research studies in the clinical and community field areas of nursing practice. (Health Learning Materials Project, 1989)

Incorporated into the philosophy of the curriculum are statements of belief about Primary Health Care and about nursing leadership. Verbatim, beliefs about Primary Health Care are:

> - Nursing in PHC is addressed to the health needs of persons throughout the whole health care continuum - primary, secondary and tertiary - in homes, schools, health facilities and hospitals.
>
> - Nurses working in PHC are prepared and motivated to take their part in the assessment of the health of individuals, families and communities, including the recognition and treatment of prevalent diseases, injuries and disabilities, and to integrate the concepts and practices of self-help througrout the care.
>
> - Nurses working in PHC are essentially generalists in that they are prepared to care for the whole persons and groups of all ages living under various conditions & with a wide variety of associated social and health care needs.

> - Nurses give priority to the care of those who are at the greatest risk from the major health problems of the country.
>
> - Among the responsibilities of nursing practice are training, support, and supervision of auxiliary nursing personnel and other community based health workers.
> (Health Learning Materials Project, 1989, pp. 2-3)

Verbatim, beliefs about nursing leadership are:

> - Nursing leaders should have a clear perception of national and institutional goals, and should be involved with decision making and problem solving at all levels.
>
> - Nursing leaders should demonstrate capability and confidence based on the knowledge of having relevant skills and experiences.
>
> - Nursing leaders should strengthen the capacity to motivate colleagues, groups and to inspire commitment to values of health for all.
> (Health Learning Materials Project, 1989, p. 4)

Students receive a copy of the curriculum in which the various nursing roles are delineated (identical to the roles stated in the certificate level curriculum) and the components of Primary Health Care (community participation, self-reliance, multisectoral approach, appropriate technology and economic feasibility) are outlined (Health Learning Materials Project, 1989).

The two year curriculum is organized around core courses (which everyone takes) and specialty courses (for hospital or community tracks). Core courses include: social sciences, common health problems throughout the life span, nursing concepts and principles, community health nursing, teaching and learning, teaching practicum (with 240 hours of field experience), leadership and management, health economics and nursing, research applied to nursing, mental health and management practicum (with 360 hours of field experience). During the first year of the program, the students majoring in hospital nursing have 300 hours of a hospital nursing practicum and 120 hours of a community nursing practicum while students majoring in community nursing have 300 hours of a community nursing practicum and 120 hours of a hospital nursing practicum. During the second year of the program, students majoring in community nursing take an additional theory course in community health nursing and have a 360 hour research practicum in community health nursing. Students majoring in hospital nursing take an additional course in nursing concepts and principles and have a 360 hour research practicum in hospital nursing (Health Learning Materials Project, 1989).

To be admitted to the BN program, a candidate must be a qualified certificate level nurse, have a minimum of three years of nursing experience and be in good health. There is a selection examination with three components: comprehensive examination in the chosen field of study; English; and problem solving. Admission is based on merit with 75% of weighting given to the selection examination, 12.5% to marks from certificate nursing program and 12.5% from evaluation of work experience, performance and area (Health Learning Materials Project, 1989). Thirty students are admitted each year (interview data).

The history of baccalaureate nursing education in Nepal appears to have been related to the needs of the expanding health care system as well as a response to international forces. The first two programs, emphasizing midwifery and community health, responded to needs to educate assistant nurse midwives and to provide nurses able to supervise their work. Thus midwifery teaching had to be strengthened at the certificate level as well. Competence of midwifery nursing personnel received focus. The adult nursing and pediatric nursing curricula expanded the concern with competence to adult and pediatric nursing. Focus appeared to shift to preparation of nurses for leadership positions in nursing, although there is a hint in the pediatric curriculum that nurses could be appropriate leaders in child care not just in nursing but across the health care system. The more integrated curriculum implemented in 1989 appears to be both a response to health needs in Nepal and a response to calls for nurses to assume an important role in Primary Health Care. Nurses need to assume leadership roles in areas currently under the aegis of nursing in addition to becoming equal team members, if not leaders, in multidisciplinary and multisectoral approaches to health care. The education being provided at the bachelor level is providing them with the tools needed to practise in newly evolving roles. The statement of beliefs about nursing roles in Primary Health Care suggests that a role in diagnosis and treatment of common illnesses has not been ruled out.

How Students and Faculty Perceive Nursing Involvement in PHC

Open-ended items on the questionnaires for nursing faculty and nursing students asked how they perceived the nursing role in Primary Health Care in Nepal. Responses have been analyzed with reference to the roles delineated in both the bachelor level and certificate level curricula. If a role was mentioned once, it has been included. Table 5 demonstrates the commonalities and differences in responses as compared to the roles delineated in the curricula. The actual words used by respondents are given. Many of the certificate level nursing students provided responses indicating awareness of the WHO definition of PHC, particularly of the principles. They conceptualized the potential nursing roles at three distinct levels:

(i) education of health professionals (producing community health nurses and providing inservice education);

(ii) administration (of health facilities); and

(iii) provision of nursing service (emphasis on services that are preventive rather than curative, restore people's health, nutrition, advise regarding family

Table 5

Nursing Roles in PHC as perceived by Nursing Faculty and Students in Nepal

Curricula	Faculty (n=80)	Bachelor Level (n=33)	Certificate Level (n=636)
ADVISOR	yes	yes	no
CARE PROVIDER	yes	yes	yes
CHANGE AGENT	no	yes	yes
COMMUNICATOR	no	yes	no
EDUCATOR	yes	yes	yes
EVALUATOR	yes	yes	no
FACILITATOR	yes	yes	yes
MOTIVATOR	yes	yes	yes
PLANNER	yes	yes	no
PROBLEM-SOLVER	yes	yes	no
SUPERVISOR	no	yes	yes
TEACHER	TRAINER	no	PROFESSOR
	MANAGER	yes	yes
	CO-ORDINATOR	yes	yes
	IMPLEMENTER	no	no
	RESEARCHER	yes	no
	DECISION-MAKER	no	no
	RECORDER	no	no
	COLLABORATOR	no	no
	REPORTER	no	no
	* ROLE MODEL	no	yes
	COUNSELLOR	yes	no
	CONSULTANT	no	no
	INNOVATOR	no	no
	ADVOCATE	no	yes
		ORGANIZER	yes
			GUIDER
			OBSERVER
			PARTICIPATOR
			CONTROLLER

*** certificate level student nurses perceived being a role model as being well-behaved, a good worker and a moral worker**

*** faculty perceived being a role model as being a leader with a "hands on" approach and as being a role model as a citizen both in the home and through involvement in social action**

planning, health education/teaching/promotion, diagnosis and treatment, referral, provide free medicine).

No certificate level student nurse mentioned giving direct physical care to sick persons as a role of nurses in PHC. Certificate level nursing students did not appear to conceptualize nurses as leaders outside of the domain of nursing although they did perceive the role of nurses as expanding to curative work at the health post level.

Baccalaureate nursing students perceived the nursing role in PHC at three levels:

(i) leader (social justice and equity, health sector development and multisectoral co-ordination);

(ii) administrator (in hospital and community health facilities but focused on nursing personnel management); and

(iii) nursing service provider (providing care by nursing the sick, diagnosis and treatment of individuals, referrals, preventive programs, first aid and community diagnosis as well as providing education as health teaching, health promotion, and guiding and supervising traditional birth attendants).

Baccalaureate nursing students did not mention nursing roles in developing the profession through nursing education. This was likely an oversight and a function of the small number of respondents.

Faculty perceived the nursing role in PHC at four levels:

(i) leader (community development, overall socioeconomic development, role model in home and as a citizen active in social action, linking development and education, formulation of national health policy, experts in PHC/consultation on health issues, health system planner, and advocate for equity and social justice);

(ii) educator of health professionals (more practical instead of theory, training other health workers, conducting workshops and seminars, publishing, and inservice for all health workers);

(iii) administrator (nursing service structure should be improved, co-ordinate vertical programs, better job descriptions, in-charge at district health posts - certificate level nurses, and nurses with BN in community health should exert leadership and supervision of community health workers at district level by being appointed as District Health Officer); and

(iv) nursing service provider (preventive programs, health inspector, diagnosis and treatment of simple illnesses, referral, treatment of emergencies, physical assessment [focus on women and children], maternal and child health care, assess and plan, environmental assessment, health education, promote primary education, focus on people-empowering education).

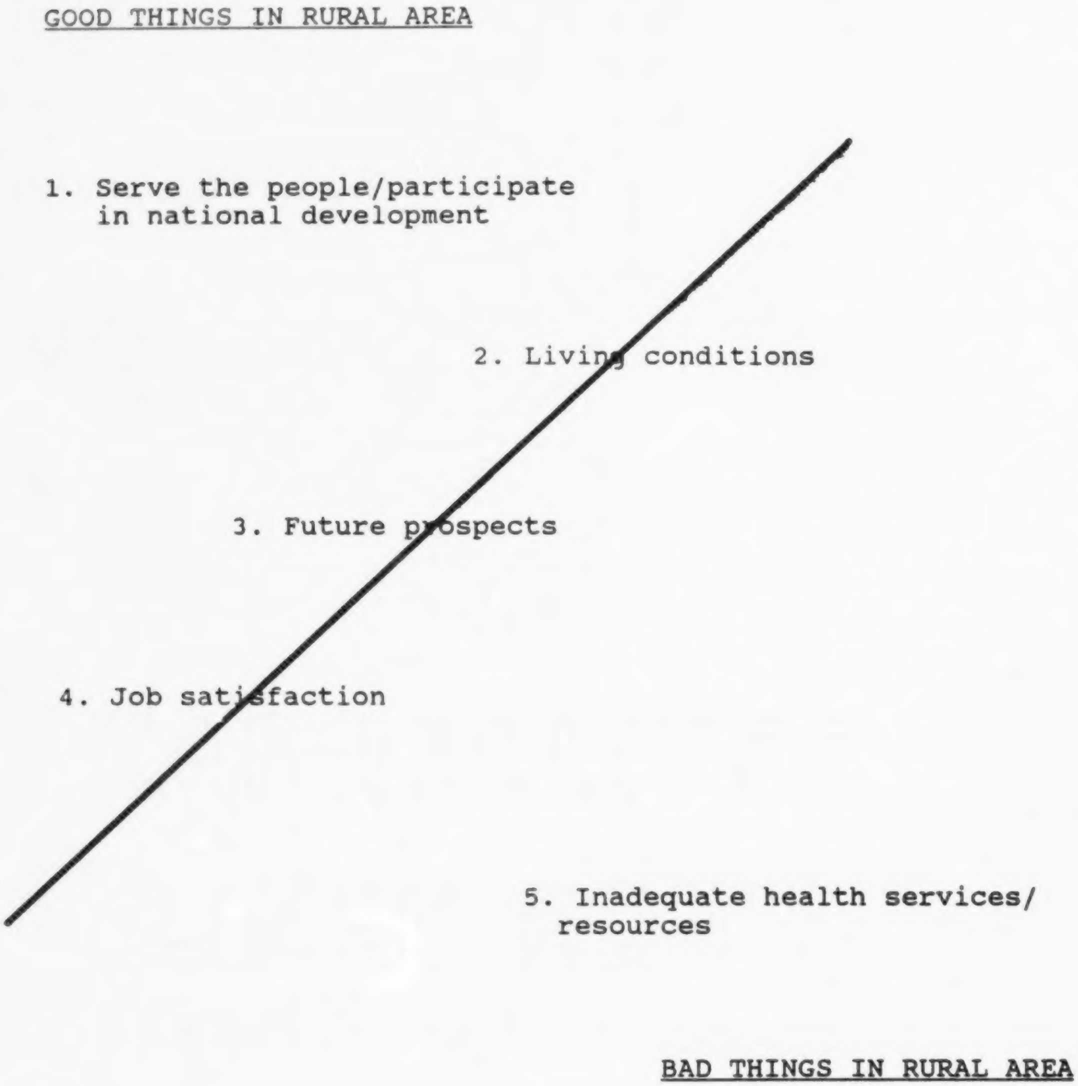
A professional orientation is very evident in the responses of many faculty. They have a much broader conceptualization of nursing roles than either group of students. What must be stated, however, is that not all faculty agree with the expansion of nursing roles to the health posts or the leadership roles which could be assumed in the health care system outside of what is more narrowly considered as the domain of nursing. These issues will be discussed more fully in the chapter focusing on interview data. Nurses in Nepal are not a cohesive group.

Forces Influencing Nursing Involvement in PHC

Open-ended items on all questionnaires requested opinions on forces influencing nursing involvement in PHC. With over 90% of the population of Nepal being rural based, the items on the questionnaire for certificate level nurses asked about the good and bad things regarding working in a rural area. Figure 3 captures their responses. Most interesting in the responses was that what some students

Figure 3

Advantages and Disadvantages of Working in Rural Areas as Perceived by Certificate Level Nursing Students in Nepal

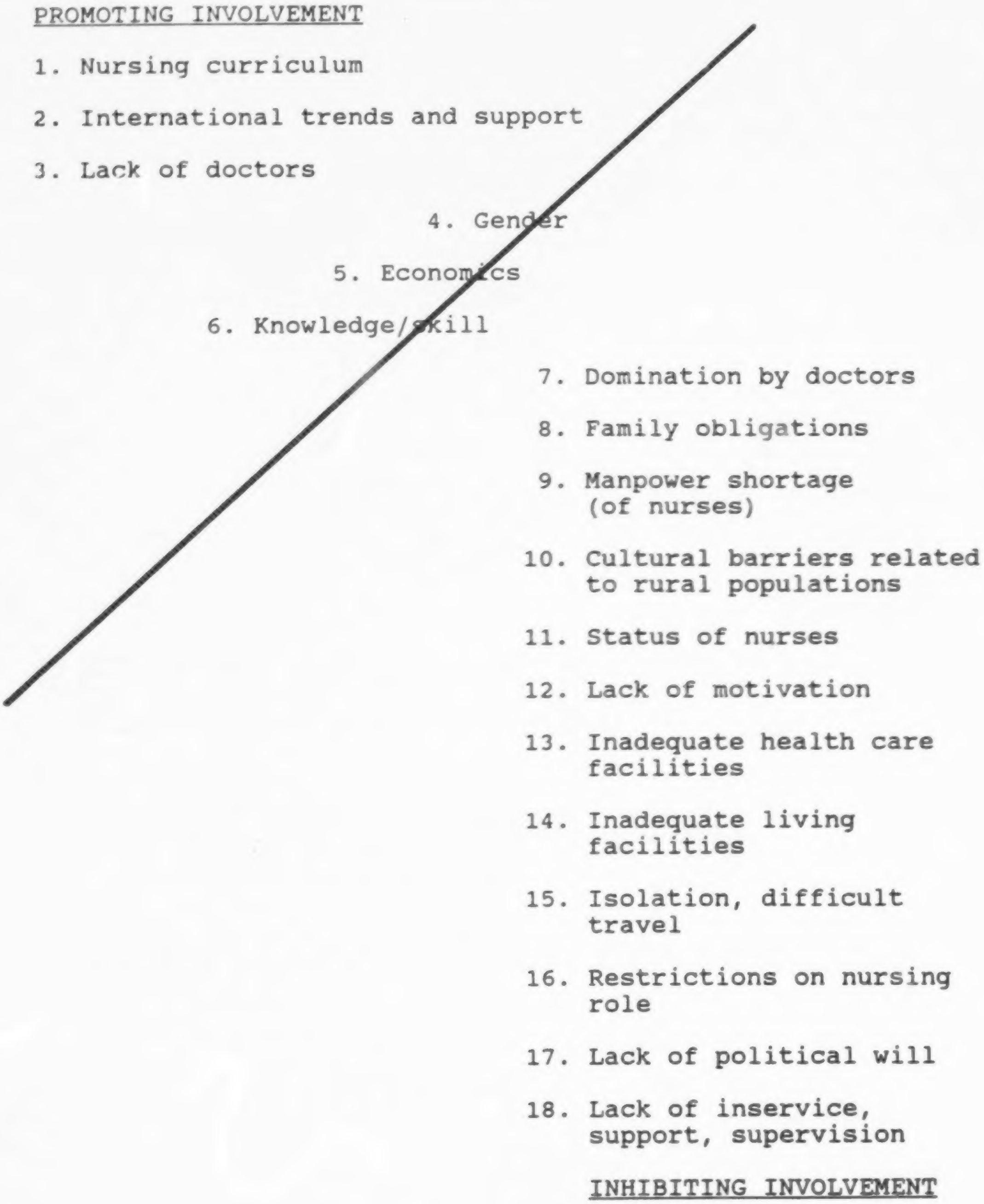

GOOD THINGS IN RURAL AREA
1. Serve the people/participate in national development
2. Living conditions
3. Future prospects
4. Job satisfaction
5. Inadequate health services/ resources
BAD THINGS IN RURAL AREA

perceived as positive about working in rural areas, other students perceived as negative. Barriers to some students were perceived as opportunities or challenges to others. Bachelor level nursing students were asked about forces which would allow nurses to assume important roles in PHC and forces which would make nursing involvement in PHC difficult. Figure 4 captures their responses. Gender, economics and knowledge/skill of nurses were factors which some BN students perceived as promoting nursing involvement in PHC whereas other BN students perceived the same factors as inhibiting nursing involvement in PHC. The BN students were much more specific in their responses. The altruism and openness to challenge of some certificate level student nurses suggests that postings to rural areas may not be rejected.

Nursing faculty were asked about forces promoting nursing involvement in PHC and about barriers to nursing involvement in PHC. The faculty responses were much more detailed than those of either group of students and are much more reflective of the complexity of the issues. International, national and professional forces promoting nursing involvement were identified. Physical barriers (geographic and infrastructural), social issues, the structure of the health care system and professional/ personal issues inhibiting nursing involvement were discussed in detail. As most interviews were with nursing faculty, their responses to these questionnaire items will be incorporated into the chapter focusing on interview data. While all questionnaires ended with an item requesting information which the informant would like to share, only faculty respondents (with a few exceptions from the other two groups) shared their suggestions for enhancing the effectiveness of nursing contributions to PHC. Responses will be incorporated into discussion of interview data in order to avoid repetition.

Figure 4

Issues Influencing Nursing Involvement in Primary Health Care as Perceived by Bachelor Level Nursing Students in Nepal



PROMOTING INVOLVEMENT

1. Nursing curriculum
2. International trends and support
3. Lack of doctors
4. Gender
5. Economics
6. Knowledge/skill
7. Domination by doctors
8. Family obligations
9. Manpower shortage (of nurses)
10. Cultural barriers related to rural populations
11. Status of nurses
12. Lack of motivation
13. Inadequate health care facilities
14. Inadequate living facilities
15. Isolation, difficult travel
16. Restrictions on nursing role
17. Lack of political will
18. Lack of inservice, support, supervision

INHIBITING INVOLVEMENT

Reflections on Nursing Initiatives for PHC in Nepal

While the Nursing Association of Nepal is conducting immunization clinics and hoping to set up a PHC demonstration project, most nursing initiatives in PHC relate to nursing education. Curricula centred on PHC have been developed and implemented at both the bachelor and the certificate level in nursing. These curricula are preparing nurses for positions that are not currently available in the government health care system. NGOs and missions, however, are prepared to place nurses in autonomous and leadership roles. Nursing faculty appear aware of the nursing opportunities envisioned in Leadership in Nursing for Health for All: A Challenge and Strategy for Action (WHO & BLAT Centre for Health and Medical Education, 1987). Nursing students are conscious of the ideology of PHC and of the potential roles of nurses. Nursing education is focusing on the preparation of nurse practitioners with the knowledge, skills and attitudes to function effectively in a variety of roles.

The next chapter will be devoted to developing profiles of nursing students and faculty. Once this has been done, the data from interviews with nursing faculty and nursing leaders will be interpreted. Interview data relate to issues currently facing nurses, why these issues are important, how social and other forces impact on nursing and what these co-researchers would like to see as the future for nursing in Nepal.

CHAPTER 7: PROFILES OF NURSING FACULTY AND STUDENTS

One of the major difficulties in developing the human resources needed for an accessible and equitable health care system in Nepal has been the centralization of personnel in the Kathmandu Valley. A common refrain, occurring in every interview, was: "Everyone wants to work in Kathmandu". Questionnaire items were devised in an attempt to develop profiles of nursing faculty and students to see what positions they may occupy or aspire to in Nepalese society. Family backgrounds of faculty were not explored for two reasons. Faculty may be more identifiable (even in pooled data) and faculty are already in positions whereby they are employed in urban areas. It is the cadre of current and future students who are most likely to be sent to rural areas. Population, not sample, data were sought from all groups and response rates were 73% (faculty), 56% (bachelor level students) and 92% (certificate level students).

Social Profiles of Nursing Faculty and Students

For the faculty questionnaire, the response rate was lowest at Maharajgunj Nursing Campus, the largest nursing campus in the country. There were 23 respondents from this campus and from nursing administrative personnel at the Institute of Medicine from a possible total of approximately 44 (I could never determine the exact number). Between 8 and 11 faculty responded at each of the remaining nursing campuses (>80% response rate). All faculty responded to all questionnaire items in English. All faculty were female. Sixty-seven (83.7%) of the respondents were Nepalese while 13 were expatriates (5 were British, 7 were American and 1 was Finnish). Table 6 compares faculty responses with those of bachelor and certificate level students on the variables of marital status, if have children, ethnicity and religion.

Table 6

Comparison of Responses of Nursing Faculty and Nursing Students in Nepal Regarding Marital Status, If Have Children, Ethnicity and Religion

VARIABLE	FACULTY n=80		BN STUDENTS n=33		CERTIFICATE STUDENTS (n=633)	
	#	%	#	%	#	%
Marital Status*						
single	23	28.7	13	39.4	454	71.7
married	50	62.5	20	60.6	178	28.1
divorced	2	2.5				
widowed	5	6.3				
no response					1	.2
Children						
yes	50	62.5	19	57.6	119	18.8
no response					4	.6
Ethnicity**						
Brahmin	15	18.8	9	27.3	200	31.6
Chhetri	12	15.0	5	15.2	92	14.5
Newar	21	26.2	12	36.4	146	23.1
Gurung	2	2.5	2	6.1	31	4.9
Magar	2	2.5	2	6.1	32	5.1
Kiranti	9	11.3	1	3.0	30	5.0
Tamang					5	.8
Mongoloid	2	2.4	1	3.0	6	.9
Tharu					8	1.3
expatriate	13	16.2				
other					8	1.3
no response	3	3.7	1	3.0	65	10.3
Religion***						
Hindu	54	67.5	30	90.9	550	86.9
Buddhist	10	12.5	1	3.0	58	9.2
Christian	14	17.5	2	6.1	15	2.4
Muslim					1	.2
other	2	2.5			3	.5
no response					6	.9

*only faculty were asked about divorce or widowhood, the divorced faculty were expatriate

**Kiranti = Limbu or Rai, Thakuri (1) is included with Chhetri, Mongoloid = Mongoloid, Lama, Tibetan, Bhotias or Lechda (as stated by respondents)

*** other respondents were expatriate, 3 Nepalis were Christian (in the faculty population)

Eighty questionnaires were returned from an approximate population of 110 faculty. Problems estimating the population arose from faculty on study leave and changes in expatriate personnel as some contracts were ending and others beginning. Deputation was also mentioned as an issue by two faculty co-researchers.

All bachelor level nursing education in Nepal is offered at Maharajgunj nursing campus. Faculty at that campus hypothesized that the low response rate in this group was related to time constraints. The nursing program extends over 6 days per week and many of these students have family obligations. Class time was not available for all students to complete the questionnaire. Bachelor level students ranged in age from 24 to 37 years (with 2 no responses in the 33 returned questionnaires out of a total enrolment of 59 students). All bachelor level students were female. All bachelor level students responded to all questionnaire items in English.

The return rate for questionnaires exceeded 80% from certificate level student nurses at all seven nursing campuses (with a 100% return at three campuses). The co-operation of faculty and students was outstanding and 636 completed questionnaires were returned out of a possible total of 692. Three completed questionnaires were extracted prior to statistical analysis as the students were from the Maldives and expected to return there after graduation. The Maldivian students were all Muslim. Certificate level student nurses ranged in age from 16 to 38 years (258 students were teenagers, 301 were in their twenties and 60 were in their thirties). Five students did not respond to the question on gender. Of the respondents, 589 were female (93%) and 39 were male. While questionnaires were administered in English, approximately 35% of students responded to at least part of the questionnaire in Nepali. These responses were translated into English by research assistants hired in Nepal.

Table 6 demonstrates that most faculty and BN students are married whereas most certificate students are single. More than 50% of faculty and BN students have children whereas only 18.8% of certificate level students have children. These differences may be explained by the differing age structures among the groups. Several co-researchers, however, referred to the number of nurses educated in the 1950s and 1960s who remained unmarried because of the low status of nurses during that time (interview data). In the faculty group, 19.4% of Nepalese respondents are single in a society where early marriage is the norm. No unmarried respondent (excluding widows and divorcees) reported having children.

Ethnicity was coded initially according to what respondents identified as their ethnic group and then reclassified slightly along divisions suggested by Bista (1987). Thus Thakuri (one faculty member and one certificate level student) are classified in the Chhetri group. Kiranti may be either Limbu or Rai. Persons who identified themselves by any of these terms have been coded as Kiranti. The grouping of Mongolian was made to encompass Lechda, Lama, Tibetan or Bhotias but not other mongolian groups as this term was given as the ethnic group of one baccalaureate student and placed in brackets for some persons who also identified themselves as Lama. The two faculty identified as Mongolian were Lama and Lechda. Of the eight certificate students identified as other, two were Sanuwar and the remaining six were each from separate ethnic groups (Sherpa, Darai, Shuddra, Jirel, Hemchuri and Thakali). Not everyone responded to the item on ethnicity. While certificate level students often needed clarification on this questionnaire item, it is possible that some respondents found this item sensitive and were reluctant to reveal their ethnic group. Interview data suggest that increasing numbers of low caste students are being admitted into the certificate level nursing program. While accurate statistics regarding population distributions of ethnic groups are not available (Bista, 1991), Bista's concern about the domination of Brahmins, Chhetris and Newars in power structures and education (confirmed by Vir, 1988) is reflected in the statistics about nursing. These three groups comprise 60% of nursing faculty (16.2% are expatriate), 78.9% of BN students and 69.2% of certificate level nursing students who responded to the questionnaires. Another 16.3% of faculty, 15.2% of BN students and 15% of certificate level students reported being Gurung, Magar or Kiranti. These groups are less disadvantaged than other ethnic groups because of their long association with the British army as the famed gurkha soldiers. All faculty and BN students who responded to the questionnaire are from advantaged groups as are 84.2% of certificate level students (who had a no response rate of 10.3%). What this data reveal is the slowness of social change associated with assimilation of disadvantaged groups but also that some change is occurring. The Tharus, a disadvantaged group from the Terai, have eight students enroled in nursing programs. The nonrespondents in this study question could also be from disadvantaged groups.

The findings related to religion are of interest. The findings related to faculty are distorted because of the inclusion of expatriate faculty. When they are excluded, 81% of Nepalese faculty are Hindu, 15% are Buddhist and 4% are Christian. Both student groups have a higher proportion of Hindus and a lower proportion of Buddhists and Christians than the faculty group. There is one Muslim student in the certificate level group. Interview data suggest that Muslim students are rare but that this is not the first one to be admitted to a nursing program. Interview data also revealed that the status of nursing is rising and one respondent suggested that a better "class" of student is now being admitted. There were substantially more Newars (who may be Hindu or Buddhist) as compared to Brahmins or Chhetris (Hindu) in the faculty population as compared to the student populations. This issue of the changing status of nurses will be discussed in more detail when interview data are interpreted. While the estimated proportions of different religious groups in the general population have been challenged as more related to the power structure than to real population figures (Bista, 1991), the estimations are Hindu (89.5%), Buddhist (5.3%), Islam (2.7%), Jain (0.1%) and Christian (<0.1%) (HMG/WHO Management Group, 1987). Thus, in the current student nurse (certificate level) population, Buddhists and Christians may be considered over represented and Muslims and Hindus under represented. Bista (1991), however, would likely suggest that Hindus are over represented and that this over representation could be of a large magnitude. Two of the certificate level students who checked other on the questionnaire suggested that they follow shamanistic religious practices.

Respondents were asked about languages spoken, read and written. The findings are outlined in Table 7. All Nepalese faculty, some expatriate faculty and all BN students reported that they could speak, read and write Nepali. A few certificate level students did not indicate facility in Nepali. This may be an artifact of the wording of the questionnaire and an indication of unreliability of responses. The other possibility is that these were students educated in India or another country. The findings regarding facility with English support my own observations. Students and many faculty appeared more comfortable reading and writing in English than in speaking it. As previously reported, some certificate level students answered their questionnaires in Nepali and interpretation of questions was necessary for some students. Comprehension of English is needed for clinical work in Nepal as patient records at the

Table 7

Responses of Nursing Faculty and Nursing Students in Nepal Regarding Languages Spoken, Read and Written by Percentage.

VARIABLE (by %)	FACULTY (n=80)		BN STUDENTS (n=33)		CERTIFICATE STUDENTS (n=633)	
	yes	no	yes	no	yes	no
Nepali*						
speak	97.5	2.5	100		98.1	1.9
read	92.5	7.5	100		97.0	3.0
write	92.5	7.5	100		97.8	1.3
English						
speak	68.8	31.3	54.5	45.5	23.1	76.9
read	97.5	2.5	100		91.5	8.5
write	95.0	5.0	97.0	3.0	87.7	11.4
Hindi						
speak	41.2	58.7	15.2	84.8	9.3	90.7
read	52.5	47.5	33.3	66.7	15.5	84.5
write	36.2	63.7	12.1	87.9	8.5	90.5
Other Foreign Language**						
speak	12.5	87.5		100	.2	99.8
read	7.5	92.5		100	.5	99.5
write	5.0	95.0		100		100
Ethnic Language of Nepal						
speak	32.5	67.5	30.3	69.7	16.1	83.9
read	20.0	80.0	6.1	93.9	4.9	94.9
write	13.7	86.2		100	2.4	96.7

* includes expatriate faculty - all Nepalese faculty speak, read and write Nepali

* there were missing values in certificate level data (very few) so the % for them does not always total 100%

** with one exception, faculty speaking another foreign language were expatriates hospitals where I visited were kept in English. Also access to textbooks and journals would be very restricted without at least the ability to read English (or perhaps Hindi). The proportion of persons with facility in Hindi (widely spoken in India) was greatest in the faculty group. Many of these faculty may have received part or all of their nursing education in India. Most faculty who reported speaking another foreign language were expatriates. The other language identified by Nepalese respondents was invariably Japanese. Japan is a major aid donor to the health sector in Nepal.

Nursing students, BN and certificate, were asked to respond to questions relating to their education as well as the educational attainment of their parents and the living conditions of their families during their high school years. They were asked about the number of brothers and sisters they have. Findings are summarized in Tables 8 and 9. Over 90% of both groups of students went to general (public) schools in high school and approximately 88% of students from both groups could attend school while living with their parents. This indicates that they lived in places with access to high school education. The majority of students indicated having brothers. In the Nepalese context, this means that both male and female children in their families were being educated. Seventy-nine percent of respondents from each group reported having fewer than six siblings so that the majority were not from the very large families common in Nepal. One certificate level student reported having 18 siblings but that was an anomaly although there were other students with eight or nine siblings. Parents of both groups of students appear to be more educated than the general population of their generation. While close to 50% of students' mothers had no education, it must be recognized that the female literacy rate was 3.7% in 1971 by which time most of the mothers would have been beyond school age. The

Table 8

Parental Education, Number of Siblings and High School Education of Student Nurses in Nepal by Percentage

VARIABLE (by %)	BN STUDENTS (n=33)	CERTIFICATE STUDENTS (n=633)
Family Variables		
Mother's Education		
none	45.5	56.1
attended primary school	45.5	27.2
attended high school	3.0	7.4
completed high school	3.0	4.1
more than high school		5.1
no response	3.0	.2
Father's Education		
none	12.1	9.0
attended primary school	27.3	29.9
attended high school	21.2	19.4
completed high school	12.1	11.8
more than high school	24.2	29.1
no response	3.0	.8
# of Brothers		
none	15.2	8.1
1	21.2	28.9
2 to 5	63.6	61.3
> 5	none	1.7
# of sisters		
none	24.2	16.9
1	15.2	26.4
2 to 5	60.6	54.0
> 5	none	2.7
# of siblings		
none	12.0	3.0
1	9.0	6.3
2 to 5	57.6	69.5
> 5	21.2	21.0
High School*		
General School	93.9	91.2
Day Scholar Boarding School	3.0	7.6
Resident Boarding School	3.0	.3
Lived With Parents	87.9	88.9
Did Not Live With Parents	12.1	10.7

* 2 certificate students did not respond to last item

Table 9

Living Conditions of the Families of Student Nurses in Nepal in 1991/1992 During Their High School Years

VARIABLES (by %)	BN STUDENTS (n=33)	CERTIFICATE STUDENTS (n=633)
Family Residence*		
city	18.2	23.1
district centre	21.2	19.4
village near a road	30.3	38.9
village < 1 day walk	15.2	10.4
village 1 or 2 day walk	none	3.6
village > 2 days walk	3.0	1.6
India or other country	12.1	2.2
Living Conditions at Family Home		
Electricity		
yes	63.6	56.1
no	36.4	42.2
Source of Drinking Water		
tap in the house	33.3	55.3
tap outside	51.5	29.2
well	15.2	10.3
stream or river	none	3.3
other	none	1.7
Sanitation Facilities **		
indoor flush toilet	15.2	19.3
indoor - no flush	24.2	20.8
pit latrine	54.5	51.2
no facilities	none	7.7
other	6.1	.5

* # of days walk refers to distance from nearest road

** other was coded when a description was given such as a specific part of a field, etc.

- the totals are not all 100% because of missing cases

Note: All BN students are graduates of certificate programs and thus the age structures of the two groups vary.

majority of fathers had at least attended high school although close to 10% from each group had no education. It is likely that most of these students are from middle class or better homes.

The data regarding living conditions seems to confirm the class status of student nurses' families. Over 50% of them came from homes supplied with electricity. Over 50% of current certificate level nursing students had taps for drinking water in their family home and 19.3% had flush toilets. Access to drinking water and sanitation facilities in the respondents' natal homes far exceeds the percentages in the general population. They could experience great difficulty if posted to clinical facilities lacking these amenities. Most students reported a family home either in an urban area or close to a road (69.7 % of BN students and 81.4% of certificate students). Again, this has implications for rural postings. The situation, however, is not hopeless as there were some students who appeared to be from less accessible villages. This data on living conditions does support that many of the students are from middle class or higher families. The data, however, is not inconsistent with a conclusion that some students may be from poor families or from isolated villages. This conclusion is given credence from some of the responses to the open-ended items on the questionnaires where some certificate level students indicated origins in poor families or a desire to return to their village as there were no health services available there.

Professional Profiles of Nursing Faculty and Students

While the entrance requirement for nursing programs in Nepal is currently grade 10 and the SLC examination pass, 51.3% of nursing faculty reported having more general education. The educational achievements of faculty respondents are outlined in Table 10. The majority of faculty had BN degrees, 15 had master's level education (only two of these respondents were expatriate although a third expatriate was working on a master's degree) and two Nepalese nurses had doctorates (and others are currently in PhD programs). Eight of the Nepalese faculty who responded to the questionnaire had completed all of their nursing education outside of Nepal. Just over half (56.3%) of faculty had received all of their nursing education in Nepal. The large number having at least an intermediate certificate may be because BN programs in India require this level of education for admission and prior to 1976 most Nepalese nurses with BN education obtained it in India. The majority of faculty had graduated in the 1970s and 1980s. Fourteen faculty, including some expatriates, did not have bachelor's degrees.

The clinical, teaching and administrative experiences of nursing faculty along with their participation in the development of current curricula and the alterations curriculum change have made in their job are presented in Table 11. Twenty-five faculty reported that they had no clinical nursing experience prior to becoming a faculty member while 25 faculty reported having had more than five years of clinical experience. Experience supervising students in clinical facilities was not included as clinical experience for faculty. There were faculty who reported having taught in the assistant nurse midwife program or at another nursing campus in the past. Six faculty reported experience as ward sisters and three as hospital matrons. Thirty-five percent of faculty had participated directly or indirectly in the development of at least one of the new curricula. Adoption of the curriculum related to Primary Health Care was viewed favourably or neutrally by most faculty who had a response as to how their job had been changed but 8 faculty reported that their teaching job had

Table 10

Educational Achievements of Nursing Faculty in Nepal

VARIABLES	FACULTY (n=80)	
	#	%
General Education after Class 10		
Intermediate (Class 12)	22	27.5
Non-Degree Course	9	11.2
Bachelor's Degree	3	3.7
Master's - Not Health	2	2.5
Master's - Health	3	3.7
Ed.D.*	2	2.5
TOTAL	41	51.3

*both doctoral degrees are from Columbia University in the USA where an Ed.D. in nursing is possible (one respondent has the nursing degree and one does not to the best of my knowledge)

Highest Nursing Education**		
Certificate	8	10.0
Non-Degree Course	6	7.5
BN	56	70.0
MN or equivalent	10	12.5
TOTAL	80	100.0

**there are non-nurses teaching at some campuses and their responses have not been included in data analysis

**2 expatriates have master's degrees - one in nursing and one in another area

Where Nursing or Graduate Education Obtained***		
All in Nepal	45	56.3
Part in Nepal	13	16.2
All outside Nepal	21	26.2
no response	1	1.2

*** The "all outside Nepal" group includes the 13 expatriates.

When Graduated from Basic Nursing Program		
1947-1956	7	4.8
1962-1969	8	9.9
1970-1979	34	42.5
1980-1989	20	25.0
1990	2	2.5
missing	9	11.3

Table 11

Faculty Experience Prior to Current Job and Faculty Involvement in the New Curriculum

VARIABLES	FACULTY (n=80) #	 %
Clinical Experience		
none	25	31.3
< 1 year	5	6.3
1 to 5 years	20	25.0
> 5 years	25	31.3
indeterminate*	4	5.0
no response	1	1.2
* indicated that had some clinical experience prior to teaching		
Highest Other Administrative or Teaching Experience		
taught midwives (ANMs)	9	11.2
taught at other campus	3	3.7
sister	6	7.5
matron	3	3.7
campus chief*	8	10.0
none	24	30.0
other	22	27.5
no response	5	6.3
* this does not include the 7 current campus chiefs unless they were campus chief in another place as well (does include ANM campuses)		
Involvement in Developing Current Curriculum		
yes	28	35.0
no	51	63.7
no response	1	1.2
How Primary Health Care Has Changed Teaching Job		
no change	8	10.0
change neutral	15	18.8
change positive	18	22.5
change negative	4	5.0
no response	35	43.8

not been affected. Interview data support that the curriculum change has been received positively by most faculty.

Of the 33 respondents to the questionnaire for baccalaureate student nurses, 15 had graduated from Lalitpur (mission) Nursing Campus, 15 from Maharajgunj Nursing Campus (or Mahaboudha - which moved to the Maharajgunj site in the 1980s) and 1 from Biratnagar Nursing Campus. Eight respondents graduated from their certificate level program in the 1970s and 24 in the 1980s. Eighteen respondents were first year students and 15 were in their second year. Two students reported having less than class 10 and 11 students reported having more than class 10. There should be no students with less than class 10 so the reliability of data could be questioned. Two students had been assistant nurse midwives prior to becoming certificate level nurses and two students had been teachers. Their clinical experience prior to admission to the program, their reasons for doing the BN and their plans after graduation are presented in Table 12. All BN students had some work experience, including 13 students with either faculty or administrative experience. Reasons for continuing their nursing education varied and some students gave more than one reason. Only 6 students mentioned wishing to increase their chances for promotion while 7 students mentioned a wish to become prepared to teach. The opportunity to gain knowledge, obtain more education or become a better nurse was mentioned by all respondents. These items were coded separately as, although they appear related, motivations may vary. Higher education is highly valued in Nepal, perhaps as an end in itself for some people (Bista, 1991). Only 4 students stated a wish to work in the community after graduation thus raising questions as to the desire of nurses in Nepal to work in rural areas.

Of the 633 certificate level students who responded, 4

Table 12

The Work Experience, Reason for Doing BN and Future Plans of BN Students in Nepal (1991-92)

VARIABLES	BN STUDENTS (n=33) #	 %
Work Experience		
staff nurse	20	60.6
administrative	1	3.0
faculty	5	15.2
combination or all	7	21.2
Reason for Doing BN*		
promotion	6	18.2
further study	7	21.2
continue hospital work	6	18.2
work in community	3	9.1
to teach	7	21.2
become better nurse	13	39.4
gain knowledge	13	39.4
other	4	12.1
no response	5	15.2
Plans After Graduation		
work in hospital	11	33.3
work in community	4	12.1
administrative	5	15.2
faculty position	8	24.2
further study	3	9.1
other	2	6.1

* some students gave more than one reason so the total is >100%

reported having less than class 10 and 168 reported having more than class 10. Before entering the certificate level nursing program, 112 (17.7%) of respondents had been assistant nurse midwives, 17 (2.7%) had been teachers and 12 (1.9%) had been engaged in farm or household activities. Seventy-two percent of respondents either did not respond to this item or reported no work period between high school and entering the nursing campus. Another 5.7% of respondents reported a variety of activities between high school and becoming a student nurse. There should be no students without class 10. Again, this may be an indication of some unreliability in the data. Some interview co-researchers, however, expressed opinions that some students had not achieved the SLC examination pass but had obtained certificates by other means. This issue will be discussed again with the interview data. Students were asked about their reasons for entering nursing, where they wanted to work after graduation and what they wanted to be doing two, five and ten years after graduation. Findings are presented in Table 13. Respondents were almost equally from all three years of the nursing program.

Almost half of the students gave an altruistic reason, such as helping the poor or the sick, as a reason for entering nursing. A few thought that they were being admitted to medicine. Getting a job was the next most common response. This need for employment may be one reason that applications to nursing have been increasing (interview data) as unemployment and underemployment of the educated are common while nurses are generally able to find jobs in Nepal. Several female students mentioned that their fathers wanted them to be independent. This could reflect a growing awareness about the status of women in Nepal.

While some students were unable to articulate what they wanted to do immediately after graduation, the majority (62.1%) voiced a desire to work in a hospital. Another 25.1%

Table 13

The Reasons for Entering Nursing and Future Plans Of Certificate Level Student Nurses in Nepal (1991-92)

VARIABLES	CERTIFICATE LEVEL STUDENT NURSES (n=633) #	%
Reasons for Entering Nursing*		
altruistic	313	49.4
parental pressure	74	11.7
liked the uniform	28	4.4
wanted admission to medicine	4	0.6
health professionals in family	14	2.2
get a job	43	6.8
response not interpretable	170	26.9
no response	74	11.7

* total is > 100% because some respondents gave 2 or more reasons

VARIABLES	#	%
Plans When First Graduate**		
work in hospital	393	62.1
work in clinic	9	1.4
work in community	159	25.1
work in health project	26	4.1
service - not specified	54	8.5
further education	20	3.2
other/not interpretable	18	2.8
no response	9	1.4

** total is > 100% because some students were ambivalent and gave more than one response

VARIABLES	#	%
Plans After 2, 5 and 10 Years (responses collapsed to one category)***		
work in hospital	253	40.0
work in community	166	26.2
work in clinic	11	1.7
service - not specified	154	24.3
administration	70	11.1
further nursing education	512	80.9
work in health project	33	5.2
teach nursing	78	12.3
become a doctor	33	5.2
go to foreign country	59	9.3
devote time to own family	37	5.8
start a medical hall/pharmacy	43	6.8
do nursing research	24	3.8
no response/don't know	79	12.5

*** total is > 100% because students perceived themselves as doing different things at different points in their career wish jobs in community health. More than 90% perceived themselves as working as nurses but 3.2% wished immediate access to further education. Several students stated that they wish to work in a remote area or go back to their village because the people are poor and lack health services.

When asked to project what they would like to be doing in two, five and ten years after graduation, students seemed to experience more difficulty. As one student wrote, in their culture they do not think about the future. Several responses made reference to fate or stated a variety of options. For example, most students who mentioned becoming a doctor did so with awareness that the option may not be available and, therefore, stated alternatives. Many mentioned an initial desire to gain hospital experience and then move on to a community nursing job. Others wished to start with a community health job but to work in a hospital later. The majority wished to pursue further education either in nursing or in medicine. It is unlikely that advanced nursing education opportunities will be available to all who wish it. A few students spoke of leaving nursing when they have families (including one male respondent). Others spoke of starting health-related business ventures. One student voiced a wish to be the top nurse in Nepal 10 years after graduation while another student envisioned becoming a politician and perhaps the Minister of Health. What was very clear was that many student nurses are ambitious and that most envision remaining in the work force.

Reflections on the Profiles of Nursing Faculty and Students

It is difficult to compare responses from the three groups of questionnaire respondents because of differences in population figures, response rates and wording or intent of items. Some of the changes in nursing education and in Nepalese society, however, are reflected in the differences. For example, as male students were not admitted into nursing until 1987, it is not surprising that there are no male BN students or faculty. The need for prepared faculty and the wish of development agencies to be involved in nursing education have led to the use of expatriate nurses as nurse educators. The rapid expansion of nursing education since the 1980s has led to the increased need for faculty.

Only the more advantaged ethnic groups in Nepal were represented in the faculty and BN populations but, while they still dominate, students from less advantaged groups are represented in the certificate level student group as are some students who report being from more remote areas of Nepal. It was of interest that there was only one Sherpa respondent as this is a group widely known in the outside world because of their expertise as alpine guides and climbers. The predominance of Newars in the faculty population is interesting. Perhaps Newar women were less protected than Brahmin or Chhetri women or less likely to lose caste status from becoming nurses in the early years of the development of nursing in Nepal. Newars are also the predominant group in the Kathmandu Valley so it is also likely that Newari girls had more access to education.

The changing economic conditions seem to be working in favour of women who have paid employment. As one interview co-researcher stated, in the early days women took the risk of becoming unmarriageable if they became nurses. It was suggested in some of the interviews that high caste parents may prefer their daughters to enter nursing rather than other higher education options because most students are female and the possibility of falling in love with someone unsuitable is reduced. Not surprisingly, most students are Hindu.

Facility in the English language was definitely a problem for some students and it is possible that some questionnaire items were misinterpreted by a few students. Most items, however, were answered appropriately. Many students appeared to come from at least middle class homes and from urban areas but there were responses suggesting that less advantaged populations are beginning to be represented in the certificate level nursing student population. With a fertility rate of 5.9 per woman in the general population, students appear to be drawn from families smaller than the Nepalese average and from families where a larger number of both parents are literate than would be generally predicted.

Nursing faculty in Nepal are well educated, including two nurses prepared to the doctoral level, several with master's degrees and the majority with at least bachelor level education. A substantial number of them lack clinical nursing experience and very few have any community health experience. All bachelor level nursing students had clinical experience but few expressed a desire to work in the community after graduation. This could reflect their knowledge of the lack of community nursing jobs.

Almost half of the certificate level nursing students provided altruistic reasons as to why they entered nursing. A few mentioned parental pressure applied contrary to their own wishes. The desire to get paid employment was another common reason for choosing nursing. While the majority of these students wish to work in a hospital after graduation, 25% indicated a preference for community health. Their nursing curriculum has an emphasis on community health and faculty have reported that nursing students appear to enjoy their community health clinical experiences. Several students expressed wishes to work either with the poor or in remote areas. Projecting into the future was difficult for many students. Over 80% of students hope to receive more advanced education in the future and most envision remaining in the work force.

Responses to the items regarding Primary Health Care suggest that "conscientization" of nursing students and faculty to the values of Primary Health Care is occurring in Nepal. In the next chapter the issues confronting nurses in Nepal, as perceived by nursing faculty and leaders, will be discussed.

CHAPTER 8: ISSUES CONFRONTING NURSES IN NEPAL

In 1988, a group of eminent internationally oriented nurses met to assess the progress of nurses with reference to achievements in health developments in various parts of the world. The resulting report Nursing in Primary Health Care: Ten Years After Alma-Ata and Perspectives for the Future (Report of the Joint WHO/ICN Consultation, 1989) outlines issues confronted world-wide. Permission to refer to this restricted document has been received from WHO. In evaluating the efforts of many nations to implement Primary Health Care it was concluded that "in a great number of instances the gap between policy-making and policy implementation remains wide" (p. 4) and that "there is an almost universal dearth of suitable qualified and experienced nurse teachers who can impart the concept of health for all through primary health care" (p. 8). Several factors affecting nursing efficacy were identified.

Physician influence in nursing education often leads to a perception of nursing education as a more simplified version of medical education thus legitimizing physician domination of nurses. Moving clinical opportunities outside of the hospital setting may lead to logistical problems (i.e. transportation) or opposition on cultural grounds (inappropriate role for a woman). Teaching/learning materials are scarce and often unavailable in the language most easily used by students. Professional, political or legislative blocks may prevail. Faculty are unfamiliar with important concepts (i.e. budget preparation). Nursing skills are underutilized.

The report continues by suggesting that changes in power structures are necessary before nurses will be able to assume the role in the health care system for which their education and experience prepares them. Political, social and legislative lobbying may be needed from many directions.

Professional, community and political support are required. It is suggested that nursing has a particularly hard struggle in countries where gender inequalities prevail. Committed nursing leadership is a pre-requisite for change but may be lacking in countries where senior leadership positions are unavailable for nurses, working/living conditions are such that capable nurses leave the profession or emigrate and when biases unrelated to merit guide selection for top positions. Co-operation between nurses from different countries may be enabling for nurses in more restrictive societies. Multidisciplinary projects where nurses participate equally may be helpful in generating professional respect and appreciation.

Nurses in Nepal have encountered barriers to increasing their scope of practice and to becoming full participants in the health care planning process. Many of them are frustrated. The current issues which Nepalese nurses are confronting were revealed most clearly in the confidential interviews.

The Nurses Speak

Early in the interview process it became very clear that nurses in Nepal do not speak with "one voice". As one co-researcher stated "there is no unity among nurses in Nepal". I concur and, while there are exceptions, a pattern emerged which seemed to partition nurses along generational lines on two of the major issues; the scope of nursing and the amount of influence nurses have at the planning and policy levels. Three generations appear to be present. Once this pattern was sensed, it was shared during subsequent interviews and interviewees confirmed my suspicion. The first generation (graduates from the 1950s and 1960s) are generally satisfied with current nursing roles and participation. Even if not totally satisfied, they do not wish to risk current gains by lobbying for change. The second generation (graduates of the 1970s and early 1980s) want nurses more involved in policy decisions and also would like to see nurses involved in the community, including the creation of staff nurse positions at health posts with the possibility of nurses being in charge. They perceive nurses as more knowledgeable and committed to health promotion and other community activities than the health assistants and reject the often stated assumption that nurses will not go to remote areas. The third generation (new graduates and current students) are perceived as militant and focused on their rights and older nurses question their commitment to nursing. Their perceptions have been captured in the student questionnaires.

Why the differences? The first generation has seen tremendous change. The entire health infrastructure has been developed and expanded during their professional careers. The status of nursing has improved. These nurses are not against progress but they are not impatient with the pace or direction of current government initiatives. The second generation have seen fewer changes. They are aware of international discrepancies in nursing roles and status and are frustrated by their perceived lack of autonomy and influence. They may have been influenced by the introduction of mass media into Nepal and the international women's movements of the 1970s. The third generation were students during the recent political struggles in Nepal and are very aware of their "rights". Co-researchers suggested that the student vote was courted by politicians during the recent democratic elections and that, as a consequence, student unions are a powerful force in advanced education. Much of the interview data confirms what is suggested in the literature and government documents although alternative viewpoints are sometimes offered.

Issues in Nursing Education

Nursing education issues will be discussed as pertaining to the students, the curriculum, the faculty and institutional constraints. In some respects, these are artificial distinctions as are distinctions between nursing education, nursing practice and professional nursing.

The Students

A major change in nursing in Nepal over the past 30 years has been in the recruitment of student nurses. In the past active solicitation was required to fill the few available places in schools of nursing. Now there are many more applicants than can be accepted and the SLC examination grades of many of the selected candidates are higher than in past years. Estimates from nursing campuses ranged from four to ten applicants for each student position. While this should mean that students are of good academic ability, the interview co-researchers have suggested otherwise. It is commonly acknowledged that cheating and other irregularities skew examination results and many faculty referred to what they believe is the practice of "buying" inflated results from sources in India. Many of the SLC certificates presented are from India (one co-researcher estimated as many as 50% of successful applicants) but Nepalese authorities feel obligated to accept them, even when dubious of the origin, for fear that nonacceptance would disadvantage students with Nepalese credentials seeking educational opportunities at institutions in India. There are no selection examinations or interviews for entry into nursing at the certificate level. To select students for reasons other than grades would violate university policy. Several faculty reported being in favour of a different selection process. There were concerns expressed about the academic abilities of some of the ANMs being admitted to certificate programs. Concerns were also raised about the difficulties encountered in recruiting students from the more remote areas where girl attendance at school is low and SLC pass rates are poor. One campus chief made the observation that students from remote areas who come in with low grades often perform very well. The quality of teaching which they received may have been poor and the student may have exceptional ability to even pass the SLC examination under those circumstances. Nursing education is cheaper than other university courses but there is a fee. In addition, one nurse co-researcher suggested that for a girl to pass the SLC examination is suggestive of not being from a poor family as there are economic consequences to families whose children (particularly girls) remain in school that long. There are no scholarships available for nursing students.

The selection process has led to a wide range of motivations and abilities in the candidates who are admitted. While some students are excellent, others are very poor. There was a perception among some co-researchers that there has been a change in the attitudes of nursing students. They are perceived as less docile, less interested, more negligent and focused on freedom. The student union is powerful and "students are a great force in the country....From the union they come and we cannot do punishment or anything." Standards of education have become difficult to enforce.

The other recruitment issue relates to gender. Prior to 1987 nursing in Nepal was a female occupation. Faculty were divided in their feelings about men in nursing. One co-researcher stated that one male student can dominate an entire class, partly because of the domination by men in Nepalese culture. Other faculty suggested that male students may refuse to give physical care to patients in hospital and may wish to identify themselves as mini-doctors rather than nurses. Other faculty were in favour of male students, who they suggested often excelled in community health. More males in nursing was perceived as a mechanism by which the status of nursing could be raised. Other faculty perceived male students as less caring than female students. Recently, male students, who comprise less than 10% of any class, requested that if male students were to be admitted, then 50% of student nurses should be male. A decision was made to stop admitting male students in 1992. The issue of male students being more interested in medicine than in nursing was not supported by the questionnaire data. Of 33 students who reported an interest in studying medicine after graduation from nursing, only 5 (15%) were male.

Another major issue pertaining to student nurses in Nepal relates to standards of education and motivation to succeed. The system is such that students are allowed to progress through the program even if they are failing most courses. With a pass mark of 40%, there are still failures although faculty reported feeling pressured to pass students. Courses are not repeated although students must pass all failed courses before receiving the graduation certificate. There are no extrinsic rewards for excelling. While cheating occurs, most faculty felt that the incidence was lower in nursing than in most other study programs. Students who finish the third year but who do not pass all courses are not hired in government nursing positions but are often hired in private clinics. The passage of a registration act for nurses would block this avenue of nursing employment by making it illegal. Discrepancies between what students are taught and what they see in clinical settings are also perceived as barriers to motivating students. There are few good role models.

Faculty perceived that more lower class and lower caste students are entering nursing than in the past but also that more upper class students were also being admitted. While students appear to socialize primarily with others of similar caste and class, no difficulties have been encountered in work relationships among students along those divisions. Faculty also reported no difficulties in hospital clinical settings but some high caste persons have refused to allow lower caste students into their homes during community health clinical experiences. In relation to social stratification based on caste, one faculty member suggested that as nurses "we have to make the revolution". Students share accommodation during community experiences as well as hostel accommodation and no difficulties have been reported. Faculty reported strategies such as hiring "untouchables" to carry water for students as an example to village people. Health education presentations, often attended by mixed caste groups, require ingenuity with regard to serving of the snacks expected by participants and give students opportunities to develop sensitivity to cultural issues.

Finally, there was the issue of whether a graduate program in nursing should be initiated in Nepal. Education appears connected to status. Thus offering a graduate program may elevate the status of nursing in the university community as well as prepare nurses for leadership positions in the health care system. There are many baccalaureate prepared nurses in Nepal who wish to pursue graduate degrees but who are blocked because of lack of funding or being unable to gain acceptance to graduate programs outside of Nepal. The BN degree from Nepal is not recognized in India. The program could be geared to the Nepalese context. One nurse with a foreign master's degree felt that much of what she learned was irrelevant in Nepal.

The Faculty

The slow expansion of nursing education until the 1980s led to a situation whereby many of the early Nepalese nursing faculty were recruited to teach directly after graduation from their basic nursing program. These faculty lacked clinical experience. Younger faculty reported having more clinical experience but most had worked in hospitals. With the emphasis on community health in the new curricula, a situation has risen whereby faculty are teaching content for which they lack appropriate academic and clinical preparation. Workshops for faculty have addressed the issue but some co-researchers identified a need for strengthening the clinical skills of faculty by requiring some practicum experience.

Nursing faculty reported frustration with the promotion and pay system at the Institute of Medicine. There was a perception that physician faculty get promoted much more quickly and that the process is inequitable. Many physicians also retain a private practice in addition to receiving a non-practice allowance added onto their salary, although this is not strictly allowed. Pay inequities are an issue. Physicians did not appear to be interested in control of the nursing curriculum and nursing campus chiefs reported having control of nursing campus budgets.

There were also inequities in the staffing patterns at different campuses. Most faculty would prefer to work in Kathmandu for various reasons and some manage to do so in spite of being posted elsewhere. Consequently, a nurse employed at a campus outside the Kathmandu Valley may be working on deputation in Kathmandu leaving the post in the periphery filled but unmanned. Other nursing faculty may be on deputation from clinical agencies. The problem has arisen partly from the rapid expansion of nursing education in the 1980s without the expansion of sanctioned faculty positions.

Faculty posted outside Kathmandu may have families in the centre and feel disadvantaged when opportunities for promotion or further education occur. The issue of source force was raised by some co-researchers and negated as applicable to nursing by others. Those who saw source force as operative in decisions regarding faculty did not always see it operating along class or caste lines as seems to happen in medicine. What probably occurs most frequently is that faculty in Kathmandu are more known to the decision-makers in the health care system or the Institute of Medicine. When opportunities arise, there is an impetus to suggest faculty likely to be successful and choices are made based both on merit and on who is known to the authorities. There were co-researchers who indicated that years of service should be the major criterion. Some nurses posted outside Kathmandu seem able to spend much time in the centre and it is possible that this trend is a modified version of chakari. The point system for determining opportunities would seem to favour persons working in the periphery but some co-researchers spoke of faculty being transferred to the periphery for short periods in order to accrue the points that would allow them an opportunity for advanced education (often in a foreign country). The faculty member involved would be aware of the reason for the transfer and about its limited term. Other faculty have spent many years in the periphery and have little hope of being posted to Kathmandu or receiving further education. There was a suggestion that connection to the royal family or to political figures increases one's opportunities for promotion, increased education or posting to Kathmandu.

There are still expatriate faculty at most nursing campuses although all administrative positions, other than the WHO Nursing Education Advisor to the Dean of the Institute of Medicine, are filled by Nepalese nurses. Not all Nepalese co-researchers perceived a need for these expatriate nurses and there was a suggestion that NGOs had used undue influence to insert volunteers into the nursing education system. The same concerns were not raised about the mission (UMN) nurses. In spite of their concerns, nursing faculty almost unanimously agreed that teaching nursing in Nepal is a much better job than most clinical nursing jobs. They have more autonomy and better working conditions.

The Curriculum

Generally, the new curricula are viewed favourably by most faculty. Some faculty expressed concerns about the community focus given that most nursing jobs are still in the hospital. It was recognized that many of the health oriented concepts were applicable to hospital nursing (i.e. the focus on health promotion can be integrated into patient education initiatives). There was a sense that some of the skills and knowledge important in hospital nursing were being neglected. Other faculty reported difficulty with the degree of integration of knowledge required to teach some of the concepts effectively. Implementation of the curricula was very demanding on some faculty. Other faculty suggested that while good, the new curricula were too detailed and that decisions had to be made to either skim the surface of some content or omit sections and deal with others in depth. One nurse expressed the need to identify content as "need to know, good to know or nice to know" and to teach accordingly. For faculty lacking relevant clinical experience, these differentiations could be very difficult. One co-researcher suggested that the lack of depth was leading to misunderstanding and misapplication of concepts.

Institutional Constraints

Faculty were very concerned with what appears to be a gap between nursing manpower production and the creation of nursing positions. While unemployment in nursing is not yet a critical problem, many graduates are reported not to find employment immediately after graduation. Unwillingness to go to remote areas contributes to the problem. Many nursing graduates are working in private sector health facilities in urban areas and some graduates are currently being recruited to work in Arab countries. One co-researcher estimated that 4-5% of Nepalese nurses choose to work abroad.

Expatriate faculty mentioned another concern that perhaps they noticed more because it is an issue institutionalized in Nepalese society. There is no university calendar of dates for examinations, intakes of new students and annual holidays (other than the long scheduled breaks). Planning becomes difficult under these circumstances. Students do not attend courses during the duration of activities like elections and are quick to think of taking strike action. Thus study programs are often interrupted by unexpected events. Unexpected holidays were announced during three of my data collection trips outside of the Kathmandu Valley and, if alternative arrangements were not made, this research would have suffered.

Issues in Nursing Practice

During data collection I was making constant comparisons regarding discrepancies in co-researchers' perceptions, differences expressed regarding nursing education and nursing practice, and variations about what I was hearing as compared to circumstances with which I was familiar such as nursing issues in Canada and in Papua New Guinea. Issues about which co-researchers differed provided an indication of the important issues confronting nurses in Nepal. I also received a sense that nursing education in Nepal is more developed than nursing service and that nurse educators are trying to shape the direction of future nursing practice and influence. What also emerged was a sense that nursing issues may be universal even though contexts vary widely across nations. Categories of concern about nursing practice which emerged from the data were role definition, standards, status, working conditions, living conditions and employment policies.

Role Definition

Strong disagreement was revealed among co-researchers regarding desirable nursing roles and scope of practice. Certificate level nurses are mainly employed in hospitals where much of their work involves implementing physicians' orders. As one expatriate faculty member observed, the way nursing is currently practised in hospitals lacks challenge.

> You have to be organized on a ward and you need training for teamwork. But if you did it together you would know patients and patients would be able to especially [know] their other problems they would more easily come to you - say social or psychological or religious or whatever matters. Now running everywhere around it is just kind of urgent things that is happening there now and they do it perfectly well. But I don't think there is exciting work. It doesn't make work interesting because it is that kind of servant role.

This lack of challenge in hospital nursing roles was reiterated by Nepalese co-researchers: "So it is just the fact of routine work and no improvement, no discussion, no questions, nothing. So there's no challenge also." Yet some co-researchers believe that nurses will continue to work primarily in hospitals as long as doctors have more influence than nurses on government funding decisions which effectively restrict employment opportunities for nurses.

Even in hospital, there is some dispute as to the nursing role. Should professional nurses be giving physical care (bedpans, baths, etc.) or should their role be more oriented to supervision of auxiliary health workers, implementation of treatment modalities and patient education activities? The nursing role in Primary Health Care will always include hospital nursing and health promotion opportunities are numerous. Administrative opportunities are also available for nurses in hospitals.

The public health nurse position was accepted as legitimate by all co-researchers and some felt that qualified PHNs could effectively become district health officers. What was disputed was whether positions for certificate level nurses should be created at the health post level. A good point was that until recently there were so few nurses in Nepal that staffing of hospitals was difficult and that with the expansion of nursing education and a projected shortage of jobs perhaps the time had come to place certificate graduates at health posts. Not everyone agreed. For the faculty in favour of the creation of health post positions, there are still areas of dispute. Should nurses prescribe medications and treatment or should a staff nurse position at a health post concentrate on community health initiatives and supervision of the maternal and child health work of the assistant nurse midwife? Should the ANM position be phased out? Concerns were raised about the educational preparation of ANMs and the young age (15 or 16) at which some of them begin practising. They are easily dominated by health assistants and it was suggested that they often get co-opted into the curative system and end up working under the health assistant rather than developing maternal and child health programs. They often are expected to perform personal services, such as washing clothes, for male health post staff. Should nurses have positions as in-charge or should the administration remain the responsibility of health assistants? The issues are complex. Health assistants and certificate nurses hold positions at equivalent levels in the health personnel hierarchy, although the educational program for nurses is longer. Health assistants are most focused on curative functions whereas, if Primary Health Care is going to be effective, a shift to emphasis on health promotion and disease prevention is required. There is a credibility issue as well. People in the community will listen most closely to the practitioner in charge and to the practitioner with the authority to treat disease. Without credibility, nurses will have difficulty developing community health programs. Finally, nurses are mostly women and health assistants are mostly men. There is an opportunity here to develop programs aimed at changing the status of women by providing role models with decision-making powers. Many co-researchers felt that physicians will block the notion of nurses prescribing medications or being in charge as positions for nurses independent of physician control would be too threatening for them to accept. They have less control over nursing as a profession than they have over the health assistants. While there is a plan to place physicians at health posts in the future, most co-researchers negated the possibility. Physicians often refuse to go to district hospitals. They are likely to be very resistant to going to health posts which are located in more isolated areas and thus provide fewer opportunities for private practice (to generate additional income). There were reports of health assistants setting up private clinics and referring patients at health posts to the clinics (where payment was expected) for treatment. This practice was perceived in two ways; as corruption, and as an attempt to deal with the scarcity of supplies at government health posts. A faculty member with experience teaching health assistants as well as community health nursing perceived a difference in the students. The nurses were more punctual and absenteeism was less of a problem. Nursing students seemed more willing to use their own money when a patient lacked sufficient funds for medication. There was a suggestion that corruption and poor work habits might be less of a problem in a system administered by nurses.

Standards

Many co-researchers voiced the thought that nursing is "deteriorating" in Nepal. By this, they meant that the quality of patient care was decreasing. The competence, attitude and motivation of many nurses were suspect.

> I think that if nurses are in hospital first they want to do duty according to the doctor's orders and they have no interest for continuing education and something. They have no good knowledge and interest and are only passing time, the majority of them. They are only passing time and they are negligent for patient care day to day.

Other co-researchers disagreed. They felt that the nursing role was changing and becoming more autonomous in terms of emphasis on patient education and supervision of other levels of personnel. A division between academic nurses with good theoretical knowledge and practical nurses with more clinical skills was suggested. Low morale within nursing was suggested as a major issue. Concerns were expressed about the lack of inservice education for practising nurses leading to drops in knowledge levels and little awareness of new issues. For example, AIDS awareness is very low among nurses. While nursing faculty and students are cognizant of shifts in attitudes and practices mandated by the thrust towards Primary Health Care, experienced nurses working in service positions have received little or no orientation to the hypothesized new roles for nurses or to the concept of Primary Health Care. Some co-researchers voiced concern that nurses often lack "devotion", "dedication" or "commitment" to nursing. The sense of vocation, which was perceived as common in the first generation of nurses, has been eroded.

Status

While co-researchers tended to agree that the status of nursing has improved in Nepal, most of them would like to see more changes. While in the 1950s and 1960s the choice of a nursing career seemed to relegate them almost to "untouchable" status and to decrease their opportunities for marriage, by the 1990s the number of applications to nursing campuses suggests that the stigma has decreased. I was told, however, of nursing faculty who still hide their occupation from family members. Nurses do not wear their uniforms in public partly to avoid being identified as nurses. Many co-researchers deplored the lack of pride that many nurses have in their own profession. The original stigma seemed related to pollution laws of the Hindu religion and to the idea of women giving physical care to unrelated adult males. Increasing status is perceived to have accrued from the association of nursing campuses with Tribhuvan University and the interest the royal family expressed by endorsing the enrolment of a princess at a nursing campus. The Queen Mother was the patron of the nursing association at one time. In addition, nurses are now perceived as having knowledge useful within a family circle and also having a contribution to make to the economic status of the family. With advanced education a means of attaining prestige in Nepalese society, the number of nurses with advanced degrees (estimated at 34-35 with master's degrees and 2 with PhD degrees and others currently engaged in study) may have enhanced the status of nurses.

Most co-researchers, however, perceive nurses in Nepal as being dominated by doctors. This appears to be both a class and a gender issue as well as related to the increasing number of doctors. Currently, there are more doctors than practising nurses and "now there are so many doctors around that nurses feel they are slaves, servants". Co-researchers reported that nurses tend to be recruited from lower classes than doctors and a comment was made that it is often the doctors' wives who look down on them most. There were some co-researchers, however, who questioned the extent of and reasons for the domination. Doctors respect competent nurses and there is hope that increasing competence can lead to more collegial relationships. Thus "some doctors are good and respect nurses". In recent years, since the medical school opened in Nepal and students were recruited from the ranks of health assistants, there has been some intermarriage between nurses and doctors (uncommon before) and this has the potential to affect relationships. There are also some families where the daughters have become nurses and the sons have become doctors.

Co-researchers expressed concerns that the low status of nurses affects their work as the general population has "no awareness of what nurses can do". In hospital, they are sometimes called "didi" (literally translated as "older sister") and, even though this is considered a term of respect, their advice may be ignored. In practice, "didi" is also used to address a servant (rather than using a proper name) or to address a village woman older than oneself if her name is unknown. There is a need for a public awareness campaign if they are going to be able to use their expertise effectively in community activities. In recent years, nurses have been more included in health policy and planning meetings but co-researchers disagreed on whether adequate nursing participation had yet been achieved. Two nurses (the Chief of the Division of Nursing in the Ministry of Health and the President of the Nursing Association of Nepal) attended the 1991 meetings but there is a discrepancy in their satisfaction on the level of participation achieved.

They were vastly outnumbered by physician representatives and given little opportunity to speak. There have also been some initiatives to have nurses employed in the Ministry of Health since the 1991 election but the effect this will have on both the status of nursing and the influence nurses will have on health policy decisions remains to be seen. The Chief of the Division of Nursing reported satisfaction with her level of involvement in health care decision-making.

Gender has also been suggested as a reason for the low status of nurses and their omission from decision-making roles in the Ministry of Health except in areas pertaining directly to nursing. The influence of gender seemed three-fold. Domination by men, manifested by exclusion of women from decision-making roles or negation of their input, was only part of the story. Self-esteem, or the feeling that one has something of value to contribute, is lacking in some women and some nurses. Finally, the social obligations of women in Nepal leave them with much less time than men to become active in the political or social arenas outside of their specific work obligations. These social obligations will be discussed in more detail in the assessment of living conditions. Some of the co-researchers did not feel powerless and rejected domination by men or physicians as the most significant factors limiting nursing power. Some co-researchers reported having been supported by men or physicians in trying to institute changes and one co-researcher stated that she had not yet met the limits of her authority in her present position. This particular co-researcher appeared to be of exceptional ability and also very politically astute but other co-researchers also exhibited these qualities. What must be recognized is that a significant number of these nurses, many of whom were from middle and not upper class families, managed to complete high school at a time when few girls were going to school and then achieved professional careers against societal norms. While not part of my formal data collection, three co-researchers told me their "stories" of how they achieved such a high education. Two were from families where the boys were being educated but not the girls. These women, both of whom had support from brothers, persisted in efforts to convince their parents that they really wanted to go to school and learn to read. Both faced obstacles and one reported being the first girl to complete high school in her area of Nepal. The third co-researcher who spontaneously told her story had parents who wanted their daughter to have an education. She also was the first girl to complete high school from her area of Nepal. She entered nursing on the recommendation of a brother who was married to a nurse and said that her family was always social-minded so there was no resistance to her choice of a career. While some co-researchers reported family opposition to their career choice, it was not unusual to be told that the co-researcher was from a "social-minded" family which, even if not supportive, did not oppose their daughter's choice of a nursing career.

Many of the nurses whom I met in Nepal presented as articulate and determined women. The stories of many of these women, particularly of the first generation of nurses, must be fascinating and making them heard could be a mechanism by which their followers in nursing in Nepal could gain greater appreciation and awareness of the determination and risk-taking of the early nurses. One of these women, Bishnu Rai, agreed that she could be identified by name. At a women's group meeting a few years ago, she told her story as part of her identification of herself. As a result, a booklet "The Story of Bishnu" has been published. Mrs. Rai is currently campus chief at Lalitpur Nursing Campus. She is actively involved as a citizen in the promotion of women's literacy and a strong advocate of the contribution that nurses can make to development in Nepal both as role models for health enhancing behaviours and as social activists. The woman honoured for International Women's Day in 1992 for the Pokhara area was the campus chief at Pokhara Nursing Campus. Another campus chief told me of her work on child welfare committees. Many co-researchers expressed conviction that nurses in Nepal have the knowledge and skill to make substantial contributions to Primary Health Care in Nepal but that the political will to increase their decision-making power was needed.

Working Conditions

Many co-researchers described the working conditions of nurses in Nepal as deplorable. Their lack of status, both from the community and from other health professionals, adversely affects morale and leaves many practitioners as underutilized resources. In district PHN positions, there are inadequate resources to implement programs and district health officers control the budget and thus control the scope of practice of PHNs. There was a perception that the role of the PHN may be restricted to supervision of ANMs because of district health officers with no real awareness of the knowledge and expertise of nurses. Supervision of ANMs in remote health posts was often difficult and not achieved because of inadequate transportation or fears of the PHN of being robbed when walking long distances. Accommodation was often not available for a PHN making a supervisory visit to a health post. One PHN spoke of using buses and rickshaws to make supervisory visits to the health posts accessible by these methods. There was a sense that PHNs, often new certificate level nursing graduates, were posted and then forgotten by the nursing establishment and that a centralized public health nursing department in Kathmandu with supervisors who would visit and support district public health nursing initiatives would better allow the PHNs to contribute more fully to Primary Health Care.

Working conditions in hospitals are poor because of poor facilities and lack of equipment as well as administrative deficiencies. Faculty at most schools of nursing reported that the nursing campuses have their own equipment (basins, soap, towels, thermometers, blood pressure equipment, etc.) which is used for student clinical practice as there may be none available on hospital wards. The availability of equipment becomes a greater issue outside of the Kathmandu Valley with small district hospitals often being extremely poorly supplied. Without water or electricity, sterilization of reusable equipment is not really possible. There may be a kerosene stove but no kerosene. Thus co-researchers described the flaming of needles with a match prior to reuse for injections and not being able to sterilize syringes between patients. Bedpans are shared by patients in hospitals. Nurses are taught about aseptic technique but the equipment and facilities needed to maintain it may be lacking. This is a source of frustration. In one facility which I visited, the matron parcelled out tiny pieces of soap to nursing staff as soap left unattended on patient units is often stolen. Theft of medical equipment is a problem. Often there are supplies in the storeroom but the person in charge of its distribution, feeling a sense of responsibility to reduce losses, will not distribute them to nursing personnel. The hospital matron does not control the supplies or have any budgetary discretion so nursing needs are easily ignored. As one co-researcher stated, when relationships with the physician in charge are good, then nurses are treated better and more of their needs for providing good care are met. Supplies are even more of a problem at health posts. For example, an ANM may not have adequate supplies of family planning medication to implement the program despite the emphasis on population control in the national health care plan. Drugs to treat common diseases may be unavailable or there may be none of the gauze needed to dress wounds. When supplies are unavailable, the credibility of health post staff is reduced. Community relations suffer.

Staffing levels are much reduced from North American standards. While nurses in hospitals in Nepal could be criticized as often being very treatment oriented rather than patient oriented, my period of observation at one of the better staffed hospitals left me in admiration of the nurse in charge. With one ANM for assistance she was responsible for approximately 30 children, many of whom were very ill. These children were not receiving the level of care they would have received in a Canadian hospital but many were being given the treatment needed to survive. My anxiety level would have been intense under the circumstances but this staff nurse was coping with the responsibility and able to be helpful to the students who were on orientation and consequently not decreasing her workload in any meaningful way. There was no way that this nurse could have detailed knowledge of all of these patients or time to attend to many of their needs. A nurse with an excellent grasp of the disease processes, good assessment skills and awareness of potential interventions for enhancement of life or health might be unable to cope with the inadequacies in the system. It is customary for nurses to work 12 hour night shifts without any breaks and assignments of 12-15 patients per nurse are usual. District hospitals of 15 beds may have no doctor (even if the position is filled) and may be run by one certificate level nurse and ANMs. It is common for nurses to receive much criticism from patients and from other health care workers.

Hospitals in Nepal are not clean by North American standards. This is partly related to the building materials used and to societal norms of hygiene. Cleaning duties are no longer expected of nurses and sweepers may be inadequately supervised. Patients are accompanied by family members who are often unaware of where to dispose of rubbish or how to use toilet facilities (as they may be unaccustomed to using them). In addition, the personal hygiene of some patients makes them "unpleasant to touch" in the words of one co-researcher and may contribute to nursing staffs' reluctance to give physical care.

Finally, salaries are low with staff nurses earning about 1500 rupees (just over $35US) per month and sisters and faculty about 2300 to 2500 ($54US to $59US) per month. One co-researcher indicated that 4000 rupees ($94) per month would be a salary adequate to meet basic needs and that the sari which she was wearing to work cost 800 rupees. Nurses can earn 4000 rupees or more per month working for NGOs. Volunteers (Peace Corps and VSO) teaching at nursing campuses are not expected to live on local salary and reported that it would be impossible to do so. This is in contrast to my own salary as a CUSO volunteer teaching nursing in Papua New Guinea in the 1970s where it was relatively easy to live on the local salary. This salary issue is not a nursing problem as much as a problem for all government employees in Nepal and is a factor often mentioned as promoting corruption and poor work habits.

One co-researcher stated: "But at the government side they have not good opportunity to show their talents, abilities and initiative. So social services, clubs and NGOs are good for nursing profession, I think". In NGOs nurses are involved with planning. They are supervised and evaluated. They are not harassed by official staff. In addition, they are better paid, receive travel and educational opportunities and are involved in collaborative activities for intersectoral initiatives. As one co-researcher remarked: "Even the dull nurses become better when they go to NGO". There was a perception that NGOs offer the best work opportunities for nurses in Nepal.

Climatic conditions also affect nursing practice. Roads and footpaths may be impassible during the monsoon. In winter, the nights are cold in much of Nepal but health care facilities are not heated. Personal comfort during working hours may be an issue.

Living Conditions

The reason most often given as to why nurses will not work in rural areas is that living facilities are poor or unavailable. This is most evident at health posts where it was reported that there may be quarters for the health assistant (male) and not the ANM (female). Women posted to these areas may have to find their own quarters in the village and pay for them or share quarters with male staff which is culturally unacceptable. Co-researchers reported that female staff at health posts have been raped by co-workers (often rendering them unmarriageable) and that the government has taken no steps to provide security for female staff. Many co-researchers felt that if accommodation and security were provided nurses would be willing to work at health posts. It is culturally unacceptable, however, for single women (and emphatically so for young girls) to live alone so society seems to accept that these ANMs are at risk. One co-researcher reported an incident of two ANMs being robbed by dacoits (bandits) within calling distance of villagers but feeling unable to ask for help as they perceived that none would be forthcoming. Mechanisms have to be developed whereby health post staff (including female staff) are accepted as important contributors to community development and thus valued and protected. In the UMN system, female staff get priority for accommodation and the position of "helper of ladies" has been developed. A village woman is hired to accompany the female health post staff member as requested. Thus a chaperon is seen to be present. Other issues are also important. Female staff at health posts sometimes have become the "second wife" of health assistants. Nurses posted to areas away from where their husbands are employed must often accept the position or lose their job. This is very disruptive to family life. Children may have to stay with their father if there are no family quarters or schools at the mother's new posting. Even if there are schools, the quality of education in rural areas is believed to be inferior to that in Kathmandu or other urban centres. The family then may be paying accommodation costs in two places. It was suggested by some co-researchers that nurses who accept the posting may go long periods without seeing their children or have husbands who, when left alone, take a "second wife".

When asked what being a woman meant in Nepal, one co-researcher responded:

> Your question is very interesting you know. In Nepalese custom the woman she's daughter, she's wife, she's mother. As a daughter should be dutiful, as a wife, she should be reserved only for one man, as a mother she should be devoted only for her children, should be devoted for her house and that is totally different than the nursing profession I think. The nursing profession wants a lot of devotion. Am I right? That's why you know some nurses could not show their abilities in their field due to the social barrier.

For this nurse, the demands of the nursing profession conflicted with her social obligations as a woman. Two co-researchers suggested that some first generation nurses remained single out of dedication to their nursing careers rather than out of any lack of choice and that this sacrifice should be recognized. One co-researcher expressed concern about aging nurses who chose to remain single and the lack of financial security that they may have to face in old age. Nurses, particularly those working hospital shifts, have no flexibility in their work schedules in terms of being able to leave work for periods of time to meet other obligations. Most nurses are not from families where they can afford household help and there are few, if any, labour-saving devices in Nepalese homes. Refrigerators are uncommon so shopping for food is a daily activity and meals are prepared from scratch thus consuming much time. There are religious rituals which women are expected to observe. There is a six day work week in Nepal so only one day is left free to meet other obligations. Some co-researchers reported having husbands who do not have jobs but who also take little household or childcare responsibility.

Some of the nurses interviewed live in extended families while others live in nuclear families. Some spoke about needing their mother-in-law's permission to work or seek advanced education. If posted to a place away from the family, the mother-in-law made the decision of what to do. These nurses expressed having little control of personal life decisions. In other cases, it was the husband's permission that was needed. Living in the extended family solved childcare issues but often increased the workload of the married nurses as husbands are more likely to help when their own mothers or other family members are not present to exhibit disapproval. I was told of young children being left locked up at home (for safety) while the mother was working. One nurse told of hiring a young girl (still a child by western standards) to care for her child and having this caregiver not feed the child leaving the child to take some uncooked rice to a neighbour and ask for help cooking it. This nurse felt negligent in her duty as a mother. A nurse who is very active in the nursing association spoke of being lucky as her in-laws are very social-minded and supportive of her outside activities and her husband raises few objections. What was evident from the interviews was the heavy work burden carried by these women. To become involved in professional or social issues beyond employment and family obligations may be very difficult or impossible. Transportation to attend evening meetings may be unavailable or too expensive. Unless they had administrative positions, rich families or husbands with good jobs, the nurses I met did not have telephones in their homes or have family access to a car or motorbike. Some faculty who had employed husbands reported that their entire nursing salary was absorbed in educating their children. Few spoke of wanting their children to become nurses. The work was too hard and the rewards too few.

Employment Policies

When asked about the issues facing nurses in Nepal, all co-researchers raised concerns about employment policies associated with hiring and posting practices, promotion procedures and decision-making about opportunities for further education. Rules and regulations are unclear and not strictly enforced. The issues of source force and deputation have already been raised. Some co-researchers, mostly first generation nurses, were most concerned about the lack of a career ladder in nursing and the fact that many nurses with long service had never been promoted or given opportunities for advanced education. Promotion is an expectation of long service and is perceived as necessary for reasons of pay and prestige. No one expects or wants to remain a staff nurse. Other co-researchers were more concerned that merit did not appear to be the main criterion for career progression. They deplored the lack of supervision and evaluation of nursing staff. There is little incentive to work hard. If you come to work, you get paid. If you do not come to work, you get paid. If you do a good job, you may get promoted. If you do not do a good job, you may get promoted. The system is perceived as inequitable. When asked whether nurses would accept evaluation criteria and use them, the faculty interviewed were certain that they would. Decisions about promotions, etc. are made in Kathmandu for health facilities throughout the country so it is who you know in Kathmandu which often determines career progression. Decentralization of decision-making was perceived as desirable by some of the nurse co-researchers.

Lack of co-ordination between departments allied to centralized decision-making was perceived as making posting of couples, both of whom may be in government service, difficult to manage. Nurses have no choice in their initial posting after graduation and postings to rural areas are not time-limited. Much time may be expended trying to arrange a transfer. The bureaucratic system of positions is confusing and cumbersome. There are temporary positions (offering little security but hiring at the local level may be possible as is dismissal for poor performance), permanent positions (created and filled at the Kathmandu level and from which dismissal is virtually impossible) and gazetted positions (mainly charge nurse level and above and for which a public service examination must be passed). Gazetted positions carry the most prestige but the public service examination was suspended during recent political changes. Nurses have remained in temporary staff nurse positions for periods of 15 years or more. The Chief of the Division of Nursing has decision-making power for temporary and permanent positions but not for gazetted positions. Nurses in permanent positions can receive educational leave or up to two years of leave to pursue other career options (working for an NGO) without losing their position (leaving the position filled but not manned). A system of extra payment for attendance at educational workshops was initiated many years ago and increases costs incurred in trying to upgrade knowledge levels.

Issues in Professional Nursing

There is no Nursing Council in Nepal and no registration law. Thus anyone may legally practise nursing and lack of a registration system means that there is no monitoring of the personnel practising nursing or the circumstances under which they are employed. Thus the number of graduate nurses practising in Nepal is not known. There was a Nursing Act but it was dissolved about 15 years ago when nursing education moved into the university system and none has been re-enacted. The Nepal Nurses Association, formerly the Trained Nurses Association, has submitted a written document outlining the concerns of nurses to the parliament. Thus some efforts are being made to address the legal status of nurses. There is awareness that nurses may need more legal protection as the educational level of the general population is raised. In the past, when a patient died, the family would accept the death as God's will but more educated families are now sometimes blaming hospital staff.

Since 1988, with help from the Norwegian Nurses Association and the Canadian Nurses Association, the Nepal Nurses Association has been trying to strengthen the sphere of nursing. Representatives have attended planning meetings at the Ministry of Health, legislative concerns are being addressed, nursing services are being offered (immunization clinics) and inservice education for nursing staff is being developed. Registration of nurses and accreditation of hospitals and schools of nursing are goals. Concerns about staff welfare are being addressed. A professional journal has been established. Links with women's and labour associations are being forged. One co-researcher suggested that a major reason for the association was to develop a forum whereby nurses in Nepal could support each other.

The association does not speak for all nurses, however, as division along political lines has been reported. The election for officers in the association was run based on affiliation with the Nepali Congress Party or the United Marxist-Leninist Party with the elected officers aligned with the Marxist-Leninist group. The current leadership is too radical for some nurses to accept. A co-researcher from outside the Kathmandu Valley observed:

> Nursing association is alive (laughs). It is alive but it is inactive. Paralysed. Only one main thing why it is paralysed situation. In our hospital, staff they don't go. They are all the time busy. They have to do extra duty and morning evening time they do more shifts so they working all the time you know. They are tired and they can't give time to us for the association meeting, program.

In addition to the professional association, some Nepalese nurses are actualizing their professional roles by actively engaging in research, publishing in journals, writing textbooks for student nurses, translating other textbooks into Nepali and speaking at national and international conferences. The Medical Research Council has been renamed the Health Research Council but nurses have not yet achieved membership on the central committee although it was suggested that subcommittee membership is possible. Some co-researchers voiced concerns that nursing in Kathmandu is becoming much "higher" than nursing in peripheral areas and that the gap between the more advantaged and less educated nurses is widening.

Reflections on the Perceptions of Nurse Co-researchers

I have chosen not to edit the words of nurse co-researchers in order to partially defend my decision to collect data in English. While many passages are grammatically awkward or incorrect, I believe that the English language skills of co-researchers were more than adequate for articulation of their thoughts and feelings.

What seems to emerge from the interview data is a sense that nurses in Nepal are well aware of the issues confronting them in trying to become key participants in Primary Health Care at all levels. While nurses do not speak with one voice or agree on all issues, there seems to be a sense of optimism that change is possible and that nurses are prepared to assume leadership positions. One co-researcher suggested that it is only in recent years that nurses have asked for representation at the planning and policy level. There is growing consciousness of the contributions that nurses can make. They are also aware that change in health care cannot be isolated from other societal demands and many nurses made politically astute observations. I will let the nurses' words speak for themselves.

> Now the change the politics in this system also. This is also liberating women and giving more opportunity and now I think women, we've become more proud and these are the factors which are helping.
>
> Gaining respect, that depends on the individual person also and how we respect others and that depends on the capability of the person also.
>
> Nurses have really shown their leadership once they are given opportunity, you know.
>
> But not all faculty are equally competent either.
>
> If WHO pushed for more nursing participation in planning, the Ministry of Health would respond.
>
> Now we have got many leaders and we are capable of handling our discipline but it's still we are not autonomous....so that I think that now the nursing leaders really have to, you know, march ahead.
>
> To shoulder our responsibility.
>
> We have to prove it.
>
> Without taking risks we cannot progress also.

> The association is a really strong thing in all the country because many things could be done by that association.
>
> So they hesitate to give higher position to the girls in government because they think ladies have less power to control.
>
> After democracy in Nepal, everyone is oriented to politics - some say I am from this party, some say I support this party but nobody thinks that we are nurse. Everybody is position conscious. They don't know what to do or they don't like to say against. I mean they don't want to take risk for their positions.
>
> We have got master's and we have got PhD and there is a growing leadership in nursing. We are becoming more independent and education may be one factor. Other one is the concept of the people and it is also changing; other, concept of the other health personnel also.
>
> It's moving. But things are moving. We have good faculty, you know, who could take the leadership position. There are people who could really take lead.
>
> Well in future I am not that pessimistic. I'm optimistic. You need to tolerate. You need to work hard and in the right places you have to work hard. It is not that you will get nothing. Only in the right places. Try to work with the medical team also. So that makes the future bright.

These nurses seem to perceive a "window of opportunity" within which renegotiation of current realities appears possible. In the final chapter, data provided by the co-researchers will be raised to a higher level of abstraction and synthesized with the documentary and questionnaire data.

CHAPTER 9: FORCES SHAPING NURSING CONTRIBUTIONS TO PRIMARY HEALTH CARE IN NEPAL

In the introduction to Gender and International Relations (Grant & Newland, 1991), the contribution of feminist thought to the research and theory of international relations scholars is discussed. The authors suggest that:

> Feminism calls into question the boundaries of the discipline, particularly those that cordon off the realm of the private from the public affairs that are the 'proper' subject of international relations. In its best known slogan feminism denies the boundary between the personal and the political. A feminist approach to international relations insists not only on the relevance of women's experience but also on its validity as a constitutive element of international relations. It draws attention to the ways in which the exclusion of women from the realm of 'high politics' has legitimized their subordination and oppression. (p. 5)

While I read this volume after my data had been collected and the preliminary data analysis completed, many of the thoughts of the contributors to the book resonate with my own beliefs. What are being described are conceptualizations of power that are congruent with Clegg's "circuits of power" framework (1989) as outlined in chapter two. The notion of empowerment as both relational (connected to the legitimation process) and motivational (related to autonomy and personal efficacy) as suggested by Conger and Kanungo (1988) is also supported.

J. Ann Tickner (1991) reviews the literature on women's conceptualizations of power. Insights derived from feminist thought include:

> Women theorists, even when they have little else in common, offer similar definitions of power which differ substantially from the understanding of power as domination. (p. 33)
>
> All of these writers are portraying power as a relationship of mutual enablement. (p. 33)

> thinking about power in this multidimensional sense may help us to think constructively about the potential for cooperation as well as conflict, an aspect of international relations generally played down by realism. (p. 33)
>
> ...conflict resolution involves making contextual judgements rather than appealing to absolute standards (p. 34)
>
> ...a scientist with a respect for complexity, diversity and individual difference whose methodology allowed her data to speak rather than imposing explanations on it. (p. 35)
>
> ...feminist literature urges us to construct epistemologies that value ambiguity and difference. (p. 36)
>
> ...feminists believe that there are multiple realities. (p. 36)

Robert Keohane (1991) calls for a synthesis of neoliberal institutionalism and feminist thought:

> Neoliberal institutionalism ... argues that institutions - 'persistent and connected sets of rules (formal and informal) that prescribe behaviourial roles, constrain activity, and shape expectations' - are as important as the distribution of power in affecting state behaviour. Feminist standpoint thinkers should find intellectual affinities with the institutionalist view of international relations, since it emphasizes power as ability to act in concert, diffuse as well as specific reciprocity, and the role of networks as well as hierarchies....From a normative standpoint the feminist emphasis on connectedness can also make a major contribution. (p. 47)

Caroline Moser (1991), based on the work of Molyneux, differentiates between the practical (based on concrete experiences) and strategic (based on cultural and socio-political inequities) gender needs of women. She states:

> Strategic gender needs such as these are often identified as feminist, as is the level of consciousness required to struggle effectively for them. Historically it has been shown that the capacity to confront the nature of gender inequality and women's emancipation can only be

> fulfilled by the bottom up struggle of women's organizations. Despite a few optimistic examples, state intervention alone has not removed any of the persistent causes of gender inequality within society as a whole and thus has failed to fulfil the strategic gender needs which for feminists are women's real interests. (p. 90)

What do these thoughts contribute to the analysis of the forces shaping nursing contributions to Primary Health Care in Nepal? I think they add credence to the inclusion of data related to both social structure and to human agency and to the importance of letting the data speak for itself. Separation of the public and private realms in which the nurses operate becomes untenable in any attempt to articulate the development of nursing in Nepal.

Towards a Theory of Nursing Efficacy

Efficacy is defined as "the power to bring about a desired result, effectiveness" (Watson, 1972, p. 261). The desired result in this case study of Nepal is development of an effective model of Primary Health Care. Thus the principles of Primary Health Care form the initial vision. For nurses in Nepal, the vision incorporates the possibility of being full participants, if not leaders, in the actualization of the goal of Health For All by the Year 2000.

Setting the Context

An attempt has been made in preceding chapters to allow the data to "speak for itself". A literature review set the stage for the Nepalese context with regard to sociocultural, economic, political and educational contexts. It became clear that foreign aid is very prominent in health care financing in Nepal and thus must influence health care decisions. The development of the formal health care system, including human resource development, received emphasis and was constructed primarily from official documents and Nepalese publications. The presentation of the development of the nursing profession evolved from the articulation of documentary evidence with questionnaire and interview data. Trends in the data identify concepts important in the preliminary development of a theoretical explication of nursing efficacy. The tentative nature of the concepts must be emphasized and no attempt has been made to develop a model as this data set represents a single case study and thus a sample of one.

Developing the Concepts

Nursing efficacy within the Nepalese context appears to be mediated by the articulation of forces at four levels; individual, professional, societal and international. Timing is crucial with periods of transition offering opportunities for social agents to engage in strategies which may shift configurations of power within a society (Clegg, 1989). From the data, four periods of transition with relevance to nursing efficacy in Nepal can be identified. Discussion of the nursing profession during each of these periods of transition will illustrate the importance of the core concept (readiness) which seems to predict nursing efficacy.

The first transition with relevance to nurses was the one beginning with the political changes of the 1950s leading to the thrust to establish a modern state with the development of an infrastructure for a national health care system. There were no Nepalese nurses in 1950 and the status of nursing worldwide was such that nursing input from international agencies was focused on the education and employment of nurses (needed to staff newly constructed hospitals) rather than on policy and planning of the system of health care. One co-researcher, however, did report on the importance of community nurses (mission) in establishing initial health services in the malarial areas in the Terai.

The second transition of importance to nursing was the movement of responsibility for nursing education from the Ministry of Health to the Institute of Medicine at Tribhuvan University in 1972. While the Chiefs of nursing campuses remained nurses, the Dean to whom they reported was selected from medicine leading to the hierarchy already institutionalized in hospitals now being institutionalized in nursing education. While direct physician interference in nursing education was not reported by nurse co-researchers, there were suggestions that nursing autonomy was reduced and domination by doctors reinforced. It was around the same time that, for reasons which I could not ascertain, registration of nurses in Nepal was lost. Planning for nursing remained under the aegis of nursing but health care planning included only "higher" level personnel.

The 1978 Declaration of Alma-Ata promoting Primary Health Care as the best strategy for achieving the goal of Health For All by the Year 2000 heralded the third transition and nurses worldwide recognized an opportunity to become more autonomous and more influential in health care policy and planning. In Nepal, however, nurses were omitted from government plans for community health except for the proposed expansion of public health nursing positions (which has still not been realized). As one co-researcher reported, the nurses in Nepal were not "ready" to become more influential. There were nurses, however, who were conscious of the missed opportunity. Internationally, nurses in WHO and the International Council of Nurses (ICN) met and disseminated literature regarding the possibilities for nurses imbedded in the shifts to Primary Health Care in many nations. The women's movement of the 1970s raised consciousness regarding gender inequities and the scarcity of women in influential decision-making positions. By the

1980s, research on health and development was revealing the importance of female literacy in raising health standards. Women and development received international focus. A decision seems to have been made in Nepal, probably with great influence from WHO, to expand nursing education. Five new nursing campuses opened in the 1980s. In addition, the focus of nursing education was redirected (by curriculum change) to focus on community skills needed by nurses to work effectively in Primary Health Care and, in the baccalaureate curriculum, to stress leadership skills. A critical mass of nurses with an orientation to community health principles is being socialized to perceive themselves as having the knowledge and skills to assume management and leadership positions within the Primary Health Care model of health services. The first graduates of these programs were in the 1990s and responses of current students and faculty to questionnaire items indicate awareness of potential nursing contributions to PHC.

The fourth transition is the political change to a multi-party democracy in the early 1990s. Political parties courted votes and nurses were not left out. Political and decision-making structures are changing. There is recognition that the bureaucracy needs to become more efficient. Decentralization of some decision-making power is advocated. Persons in many key positions have changed. There is optimism among many of the nurse co-researchers that change is possible at this time and that opportunities should not be missed. Thus the core concept of "readiness" appears to include the intersection of individual, professional, societal and international forces.

Concepts Related to Individual Forces

In the interviews, co-researchers spoke about consciousness, competence, commitment, challenge and confidence as being crucial to nursing efficacy. Each of these concepts will be discussed briefly.

Consciousness is the awareness of alternate possibilities. This awareness has been generated in nursing students and faculty but there is still a need to socialize practising nurses into expansion of nursing roles and responsibilities. Co-researchers appeared aware that increasing nursing autonomy should not be done without attention to issues of accountability. There appeared to be recognition that the skills of professional nurses were being underutilized in Nepal partly because of restrictions in nursing practice and partly because of the lack of motivation and initiative in practising nurses. Curriculum change appears to have been instrumental in raising consciousness.

Competence relates to the quality of care provided by individual nurses. Initial BN curricula seemed to address the need for increases in nursing competence in the areas of maternity, community, pediatric and adult nursing. The nursing association is becoming involved in some inservice education. Many co-researchers expressed concern about nursing standards and the lack of evaluation and supervision systems in nursing (as in other government positions). Inadequacies in nursing education and nursing practice which can be associated with the competence of graduate nurses were discussed in Chapter 8.

Confidence relates to success. It thus relates to having an infrastructure which promotes feelings of competence. Co-researchers reported that nurses receive much criticism from patients, families and other health care workers. The job satisfaction reported by nurses working for

NGOs indicates that in some situations in Nepal nurses are employed in areas where they feel confident and challenged.

Challenge refers to being able to test and extend one's limits. Several co-researchers mentioned the lack of challenge in hospital nursing as it is currently practised in Nepal. A co-researcher with experience as a public health nurse spoke of being constrained from actualizing her potential by a district health officer whose perception of the PHN role was restricted to supervision of ANMs. Lack of challenge may lead some of the more creative nurses to seek employment in other areas.

Commitment is the willingness to expend energy and make sacrifices in order to achieve a goal. Co-researchers spoke of the need for nurses to be committed to nursing as a profession and to giving high quality nursing services. There was a perception that many students are now entering nursing for the employment opportunity rather than out of a real interest in working to raise health levels in the population. Questionnaire data from students at the certificate level, however, revealed altruistic motives in 49.4% of respondents. Commitment appears related to motivation and working conditions for nurses lack many of the facilities and institutional structures which could lead to high job satisfaction. In addition, the living conditions of many women (and nurses are predominately women in Nepal) leave them with little time or energy to pursue professional activities outside of their regular job requirements. The six day work week leaves little time to fulfil personal obligations. The multiple roles that women in Nepal (as in other societies) are expected to fulfil mitigate against full commitment to careers. Some co-researchers reported having little control over life choices. Career decisions may not be possible without the consent of one's mother-in-law or husband.

Concepts Related to Professional Forces

In the interviews, co-researchers identified cohesion credibility, collegiality, voice, responsiveness to societal needs and legal status as important criteria for increasing the visibility of members of the nursing profession as decision-makers in health care. Each of these concepts will be discussed briefly.

Cohesion refers to unity or the ability to speak and act as a unit. The issue of a lack of unity was addressed in Chapter 8. There are generational, educational and political differences among nurses in Nepal which affect their attitudes and their thoughts as to the desired goals for the profession. Thus efforts to lobby for change could be thwarted by the inability to speak with "one voice" on relevant issues.

Credibility refers to being believable. It is thus intimately connected to competence, an individual attribute, and to responsiveness to societal needs. There seems to be consciousness developing in many of the nurses who were interviewed that they must establish their credibility in conjunction with asking for greater participation in Primary Health Care. What may be paradoxical is that to establish credibility they must first be noticed and that to be noticed they must first seek attention. Thus one co-researcher's observation that nurses are only beginning to ask for inclusion at planning and policy levels may be crucial. Opportunities to demonstrate what nurses have to offer at the clinical and community development levels (currently most developed in NGO positions) are also of immense importance.

Collegiality implies respect for the abilities of others and is important both among nurses and between nurses and other members of the health care team. In Primary Health Care, collegiality is also an important concept for development of multisectoral initiatives and for relationships with members of communities hoping to improve the conditions of their lives. Co-researchers reported few collegial relationships with other disciplines and domination by doctors was a concern of many (but not all) of the nurses interviewed. Except for some NGO opportunities, co-researchers felt that nurses in Nepal have very little opportunity for intersectoral collaboration. These opportunities are not part of the structure of nursing education. The community clinical experiences during the first year of the certificate level nursing program and during the baccalaureate program encourage collaboration with participants at the community level. True collaboration at all levels probably requires some attention to the issue of collegiality.

Voice is both the ability to articulate one's position clearly and to gain access to a forum where one will be heard. One co-researcher suggested that physicians have been very attuned to the use of the media (i.e. newspapers) in advertising their contributions to society whereas nurses have missed many opportunities to communicate their work to the community. Nurses have recently gained representation on national health planning and policy committees but appear to have little voice in the management of health care at the service level except in areas directly related to nursing personnel or direct patient care.

Without responsiveness to societal needs and the ability to voice their contribution, nurses will never assume leadership or full partnership in efforts to achieve Primary Health Care. Again, the nursing curricula implemented in 1987 and 1989 were developed in response to national health priorities, international research findings and the concept of Primary Health Care. The model of Primary Health Care implemented in Nepal appears to be highly centralized with programs planned in Kathmandu rather than in response to the voiced needs of communities.

Legal status for nurses usually pertains to licensure or registration and a nationally sanctioned Nursing Practice Act. As previously discussed, registration for nurses was suspended in Nepal in the 1970s and a document seeking legal recognition as a profession has been submitted to parliament by the Nepal Nurses Association. Without a registration act, standards of nursing practice, if they existed, would not be enforceable. Thus registration can be viewed as a mechanism for increasing accountability and promoting meritocracy (Larson, 1977). It can also be viewed as a move to claim territorial rights within the health care system (Esland, 1980; Larson, 1977; Johnson, 1972). Territoriality amongst health professionals may violate principles of Primary Health Care.

Concepts Related to Societal Forces

Societal forces are those mediated by the national context in which change is occurring. Infrastructural, political, economic, sociocultural and educational development are key issues in delineating context. Natural indicators such as geography, demography and epidemiology are also important. The literature review of these variables can be found in Chapter 3. The key concepts drawn from the interviews include infrastructure development, political will, economic feasibility and respect.

Infrastructure development includes the basic framework through which any organization (in this case the country of Nepal) functions. Any analysis of Nepal requires acknowledgement that measures to build a modern state began only in the 1950s after a century of isolation and exploitation from an oppressive feudal state. The predominately rural population was kept isolated by lack of transportation and communication systems and restriction of education to the male elites. Social stratification based on class and legitimized by caste consolidated the power base of the elite minority. Topography and, to a lesser extent, climate make transportation and communications systems difficult. Infrastructure development for health in terms of facilities and numbers of personnel are summarized in Table 2 (p. 62). Issues related to the poor clinical and living facilities in remote areas have been discussed. Problems within the bureaucracy both endemic to the entire society and specific to both the health care system and nursing have already been presented. Career progression appears more related to source force or ascriptive characteristics than meritocracy and efficiency is uncommon. There are many concerns about the quality of health care. It is obvious that much has been achieved in infrastructure development in Nepal but that there is still a long way to go. What is encouraging is that nurse co-researchers could identify the issues and were able to articulate that part of the responsibility may rest with individual nurses. These assertions appear to refute (at least for some individuals) Bista's argument (1991) that fatalism is inhibiting development in Nepal. Motivation to achieve comes from both extrinsic and intrinsic sources. Working and living conditions, particularly to attract and retain rural personnel, need improvement but nurses also have to increase their awareness of what is socially just and how nurses can contribute to societal change. Interview and questionnaire responses indicate that some level of "conscientization" is already occurring in the nursing population.

Political will refers to political decisions related to distribution of resources and to who has access and credibility at the decision-making level. Whose "voice" is receiving attention? With 35% of Nepal's foreign exchange revenue (Wheeler & Everist, 1990) and 53.7% of the 1986/7 health expenditures (Basic Minimum Needs and HFA/2000

Steering Committee and HMG/WHO Management Group, 1988) coming from foreign aid, it must be acknowledged that distribution of resources is very likely to be heavily influenced by international priorities. Government commitment to Primary Health Care may have been mandated by the need to secure external funding. While there is evidence of systematic discrimination against women in Nepal, recent legislative changes have addressed the legal status of women and gender equality is entrenched in the new constitution. As many women know, however, equal legal status is no guarantee of equal social status. Placing women on decision-making committees does not guarantee that their input will be valued. Nepal has come a long way since the 1940s when it was illegal to teach a girl to read. There is a new multi-party democratic government and it is hoped that some of the power bases are shifting. Nurses have requested and been granted some recognition and some representation on national health planning and policy committees. Not all nurses are happy with the extent of nursing participation or with the nurses chosen to represent them. Politicization of the nursing association, with the Marxist-Leninist group currently in power, could be an issue as the Nepali Congress Party won the national election in 1991. The brief submitted to parliament by the nursing association had not received a response by the time I left Nepal. Doctors are still much more powerful than nurses in influencing political decisions and the current Minister of Health is a physician, although this does not have to be a negative force for nurses as some co-researchers perceived him as a "good man" who knows how to "listen". As such, he could be less vulnerable to medical domination than a minister with less knowledge of health issues and priorities. A concern of nurses was that the nursing leaders, those with access to decision-makers, articulate clearly and with confidence the nursing concerns. To do so may be risky and yet not to do so would effectively silence nursing input while creating the illusion of nursing participation. That nurses do not have "one voice" and a clear set of goals diminishes the potential for nursing influence at the national level. The expansion of nursing education in the 1980s seems to reflect political recognition that nurses can make a substantial contribution to health.

Economic feasibility relates to what it is possible to achieve given the current and potential financial constraints. Thus there is an imperative to create a financially sustainable health care system. The Primary Health Care movement gained prominence in recognition of the need to match fiscal responsibility with social justice. A recurring thought during my interviews with nursing co-researchers was that nurses in Nepal are an underutilized resource. They form a corps of one of the most highly educated health care workers in the country and probably work in the least autonomous roles. Two questions emerge from this thought. How has this come about? Is this fiscally responsible? The first question will be discussed in the section on the concept of respect. Nursing education is expensive and it should be a political priority to ensure that the knowledge and skills of graduates are used effectively. Government positions for nurses, however, are primarily in hospitals to which the vast majority of the population of Nepal has no access. Nurses themselves have addressed this issue by developing curricula focused on community health concepts and structuring community clinical experiences to focus on community diagnosis, community development, management and maternal-child health. While Public Health Nurse positions often tend to emphasize maternal-child health, primarily through supervision of Assistant Nurse Midwives, would it not make more sense to have this level of professional nurse also supervise all health post community health activities and thus the work of

Village Health Workers and Community Health Leaders? If PHNs are to supervise these activities, then it seems to follow that professional nurses need opportunities as graduate nurses to gain the experience and confidence in community development work that can only come from experience in the field, not just as supervised students but also as independent practitioners with the authority to direct their own work in response to community needs and priorities. To do so, staff nurse positions at health posts need to be created and effort has to be directed at developing facilities and environments where female staff have adequate housing and security. This requires financial input but the effort could be very cost-effective in relation to long-term outcomes. Preventing disease costs less than treating it. Perhaps research-based demonstration projects using different configurations of health personnel at health posts are needed in order to determine optimal staffing patterns.

Respect was a word used by co-researchers in many of the interviews. There was a perception that nurses are not respected by other health professionals or by the community as a whole. There was also a recognition that respect is a reciprocal process. One must give respect in order to receive it. Many of the issues that co-researchers associated with respect have already received attention in other parts of this document and will only be mentioned briefly. Respect accrues from recognition of one's worth. Nurses have been multiply disadvantaged in Nepal. They are female in a society where women traditionally have been excluded from decision-making roles outside of the family. They are predominately from the middle class in a society where political power has traditionally been controlled by an elite upper class. They are in a profession that has generally been perceived as subservient to medicine, a profession in which practitioners have been predominately male and upper class. They are in a profession in which some of their professional responsibilities (dealing with bodily secretions) coincide with work traditionally done only by the "untouchable" caste. One of the older co-researchers told of her hurt as a young nurse when high caste patients refused to eat while she was present or made remarks indicating contempt of her status. While class/caste/gender barriers have become more flexible in recent years among the urban and educated populations, nurses still confront these issues in rural communities. Nurses need reinforcement that what they have to offer is of value to the society. If respected, they probably have much to offer as professionals, neighbours and family members in the areas of child care, nutrition and family planning, all areas of major concern in Nepal.

Concepts Related to International Forces

Three concepts related to international forces emerged from the interviews. They were opportunity, solidarity and technological and financial support. Each of these concepts will be discussed briefly.

Opportunity refers to being given a chance. Nurse co-researchers expressed appreciation for the opportunities that nongovernmental organizations have given for nurses to demonstrate their abilities in roles expanded beyond those available in government health services. Many nurses have gained in competence and confidence and have expressed their satisfaction to other nursing colleagues. Advanced education has widened the horizon of many nurses. Participation in international conferences has changed nurses' perceptions of their limits and exposed them to new ideas.

Solidarity, defined as "common interest and active loyalty within a group" (Watson, 1972, p. 842), refers to the feelings of affinity accrued from interactions with other nurses from other social contexts. During the interviews many Nepalese nurses referred to their relationships with expatriate nurses working in Nepal. Both supportive and nonsupportive incidents were related. Co-researchers also spoke of relationships with expatriate consultants, classmates from time spent studying overseas and nurses met at conferences. Membership in the International Council of Nurses and attendance at the ICN conferences were perceived by one co-researcher as important for communicating the universality of many of the issues confronting nurses in Nepal. Sharing of perspectives through publications and interpersonal communications was perceived as valuable in promoting understanding of common issues in diverse contexts.

Technological and financial support from nursing associations were viewed as ways in which the international nursing community was demonstrating solidarity to nursing struggles in Nepal. Financial support from the Norwegian Nurses Association has enabled the Nepal Nurses Association to purchase a building and thus have a permanent address (rather than having mail sent to the president's address and thus rerouted after each election). This has also enabled the association to hold immunization clinics in Kathmandu. The Canadian Nurses Association has provided consultation in the development and strengthening of the nursing association, including generation of the written brief to parliament and development of inservice education opportunities for nursing staff in peripheral hospitals. The World Health Organization has two nursing advisors in Nepal. Nursing faculty have been supplied by the United Missions to Nepal, Peace Corps and Volunteer Services Overseas.

Synthesis of the Concepts

More research, in the form of case studies in other contexts, is required to see if the same categories and concepts emerge or if the concepts can be defined more precisely. Concepts within and between categories are linked but it is premature to develop the linkages as this case study represents a single sample. The tentative categories and concepts are summarized in Figure 5.

Nursing Efficacy and Primary Health Care in Nepal

The participation of nurses in Primary Health Care in Nepal has been discussed in relation to the employment of nurses, the education of nurses and the influence of nurses in decisions relating to health. What seems to emerge from the analysis is a sense of a potential for change in a system where professional nurses, except for employment in some missions and other NGOs, have had little influence. There appears to be both leadership potential and commitment by some members within the profession to develop strategies to make nurses full partners in striving for the goal of Health for All by the year 2000. Employment opportunities, however, still mandate that most nurses work in hospitals and there is no unified voice in nursing lobbying for expansion of community health positions. Even if opportunities were available, incentives promoting nursing involvement in the more remote areas are inadequate. There was a perception among co-researchers that working in district hospitals in peripheral areas decreases one's opportunities for advancement or for eventual work in the centre.

In contrast to the current employment structure in nursing, nursing education initiatives in Nepal are being directed to the preparation of practitioners socialized into

Figure 5

Categories and Concepts Towards a Theory of Nursing Efficacy

* READINESS forms the core concept.

Individual Forces
CONSCIOUSNESS
CONFIDENCE
COMPETENCE
COMMITMENT
CHALLENGE

Professional Forces
COHESION
CREDIBILITY
COLLEGIALITY
VOICE
RESPONSIVENESS TO SOCIETAL NEEDS
LEGAL STATUS

* READINESS

Societal Forces
INFRASTRUCTURE DEVELOPMENT
POLITICAL WILL
ECONOMIC FEASIBILITY
RESPECT

International Forces
OPPORTUNITY
SOLIDARITY
TECHNOLOGICAL AND FINANCIAL SUPPORT

a social justice model of health care by virtue of the curricula in the two programs. Clinical experiences, both in the community and in the hospital, could easily be structured to focus on social inequities and strategies for change. Student nurses appear to be coming from increasingly diverse backgrounds and their personal experiences could easily be shared. While most baccalaureate level students appear to want hospital positions, slightly over 25% of certificate level student nurses reported wanting community health positions and several spoke of a desire to work in a remote area or with the poor (even though this information was not requested on the questionnaire). Students wishing to go to rural areas gave increased challenge and increased chance for independent work as reasons. It is possible that the new generation of nurses will be more proactive than preceding generations. They have been socialized into the political process by recent political changes and student power has become an issue on some campuses. Expansion of nursing education will also have an impact. The number of professional nurses in Nepal will very soon surpass the number of doctors. Hospital positions will be filled and opportunities for employment in urban areas will likely decrease. Financial pressures are likely to motivate nurses to accept more rural postings. As education, particularly primary education, expands to more remote areas, prejudices of communities with regard to gender and caste are likely to decrease and more girls are likely to go to school. Thus security of female staff may become less of an issue and more students may be recruited from disadvantaged areas and groups.

There seems to be some political will to include women in positions of influence. It is just a beginning and the numbers remain small. There will be much pressure on the women chosen to establish credibility and to make women's voices heard. As perhaps the largest group of organized professional women, nurses are gaining representation and perhaps have more opportunities than have yet been recognized. Translating representation into voice will require support and perhaps some risk-taking. Nurses involved in the Nepal Nurses Association have recognized these points and thus the divisions among nurses are regrettable. Nursing input at high levels may be essential if nursing participation in Primary Health Care is to be increased. Few co-researchers perceived nurses as becoming the leaders in Primary Health Care in Nepal. What they envisioned was becoming full partners, a goal very consistent with the ideology imbedded within the principles of Primary Health Care.

Reflections on the Context of Primary Health Care in Nepal

The transition to Primary Health Care in Nepal is occurring during a time of tremendous change within Nepalese society as a whole. Infrastructure development in all sectors has been rapid and there is concern that social change, epitomized by values inherent within the society, has not kept pace. Recent changes in the political structure are likely to be resisted by the economic elite who have also tended to be the political and intellectual elite. Nepal has traditionally been a highly stratified society with class/caste barriers legitimizing the formal power structure. Since the 1950s laws favouring traditional elites have been replaced by a constitution and by laws prohibiting discrimination based on caste or gender. Poverty, however, is increasing and as education expands to the periphery and to less advantaged groups, social unrest is likely to increase unless the new government is extremely creative and effective in addressing current social concerns. People in Nepal, including the educated elite, are accustomed to hierarchical structures and this centralized planning is still a strong feature of the bureaucracy.

Even when decentralization is discussed, it is sharing of power at the zone level (there are 14 zones) or the regional level (there are 5 regions) which is intended. True grassroots participatory power sharing appears alien to the decision-makers in Kathmandu. It is also an alien concept to most of the population of Nepal. Just as efficacy in nursing appears related to consciousness, efficacy in communities may be dependent on a "conscientization" process as described by Freire in Pedagogy of the Oppressed (1983). Poverty, environmental degradation, population pressures and unemployment/underemployment are likely to remain critical issues in Nepal for the foreseeable future. Foreign aid and international influence in domestic policy are unlikely to diminish.

During the interviews, the term "ke garne", meaning "what to do" was mentioned repeatedly as a common Nepalese expression by the non-Nepalese co-researchers. Many non-nursing Nepalese intellectuals expressed the same sentiment. When I commented on the beauty of Nepal, a common response by Nepalis was "but we have so many problems". What was striking was that not one Nepalese nurse expressed the hopelessness imbedded within the responses of many of the other individuals with whom I had contact. Many Nepalese nurses expressed frustration but there was always an underlying thread of hope. How can this discrepancy be explained? The Nepalese nurse co-researchers were all part of a privileged group in that they were nursing faculty or nurses in high positions within the health care structure. They are aware of the implications that changes in Nepalese society may have for them both as nurses and as women. They are starting to find their "voice". While empowerment as a concept has lost favour because it is patronizing to suggest that one can do something to empower another, there is still a sense that perhaps some of these nurses have undergone a process of empowerment. Structural barriers to participation as partners in health care are diminishing and consciousness of the value of nurses and their potential contribution to national development is increasing. Many of these nurses expressed feelings of personal and professional efficacy. There was a perception that their future depends partly on their own actions. Self-reliance, not fatalism, was advocated.

Final Reflections

An initial intent of this research was a test of the methodology to see if meaningful and comprehensive data would be gathered. I believe that the goal was met. What remains to be ascertained is whether the Nepalese co-researchers agree with the final construal. It is their critique which will be most useful and most relevant. What are the areas of agreement and disagreement? What has been missed? What has been portrayed inaccurately? For the research process to be complete, their assessment is required.

Suggestions For Action

Derivation of implications from the analysis of findings must be done with caution. Without consultation with Nepalese nurses there is great danger of introducing my Western biases. Thus future dialogue with the co-researchers is essential for assessment of the merit of any suggestions for action. Approaches which may prove effective in Canada could be counterproductive in Nepal. Outcomes are influenced by context. Having said this, however, I have some thoughts about actions which could facilitate nursing efficacy in the Nepalese context.

The Individual Level

Practising nurses and other health personnel need orientation to the values and strategies of Primary Health Care. Inservice education and workshops, primarily multidisciplinary, could be useful for raising consciousness and promoting collaboration. Experienced nurses would benefit from an introduction to health promotion and teaching/learning concepts.

Competence could be encouraged by recognizing and valuing excellence both in nursing education and in nursing practice. Strategies for attracting and selecting the best possible students need to be developed. Interviews and entrance examinations may be helpful but the financial and human resource costs would have to be assessed. A mechanism for admission of students from more remote areas or from disadvantaged social groups who meet entrance standards but lack competitive grades could be adopted as an intervention likely to promote social change. While the stipend for nursing education is lower than other university fees, students still require some financial resources. Consideration could be given to starting a scholarship and/or bursary program for qualified applicants from poor families.

Workshops to enhance faculty competence in teaching and in nursing have been held periodically and should continue. Perhaps clinical teaching should receive more emphasis. As faculty knowledge increases, there is likely to be less reliance on lecture presentation and more opportunity for interactive problem-based learning. Perceiving the faculty role as facilitation of student learning rather than presentation of factual information could be an integral means through which community development strategies could be modelled in nursing education. Additional library and other resources would be required to radically change teaching methods at some of the nursing campuses. Academic and clinical competence could be rewarded with recognition in a way which is meaningful in the society. Minimum standards of achievement for academic progression could be articulated and enforced as could disciplinary actions for cheating and other academic misdemeanours.

Clinical evaluation of students could be oriented towards promotion of professional practice. The most useful criteria with which I am familiar for identifying clinical failure are ones developed at the University of Alberta. Students could fail a clinical rotation by exhibiting any of the following behaviours: (i) the potential to cause harm; (ii) failure to exhibit progress over time; and (iii) failure to respond to constructive feedback for improvement of nursing care.

Faculty enforcement of educational standards must be sensitive to societal value systems and to realities of student power. Advisory committees for nursing education could be established. Community representatives, faculty and students could mutually explore the issues and establish guidelines. Competence in graduate nurses could be encouraged by administrative structures which recognize and reward excellence. Such structures are better viewed as professional or societal forces. Socialization of student nurses, however, includes the values and attitudes instilled in educational programs. Faculty need to be cognizant of the hidden agenda in the curriculum and sensitive to the subtle pressures influencing students which could have impact on later motivation and commitment to the profession. Opportunities for independent decision-making under supervised conditions where feedback is available will best prepare nurses for autonomous roles in Primary Health Care. While best described as individual forces, confidence, challenge and commitment are mediated by professional and societal forces.

The Professional Level

Problems confronting nursing as a profession in Nepal have already been outlined as have some of the initiatives taken to address them. Divisions within the profession need attention or politicians will be able to use areas of conflict to block nursing initiatives. This does not mean that divergent views should not be tolerated but rather that an atmosphere of mutual understanding and respect within which meaningful dialogue is encouraged must be fostered. The professional association could be the best way to facilitate participation by a wide range of nursing personnel but only if the elected officers at all levels are able to overcome ideological, educational and generational differences. Strategies facilitating appreciation of what all nurses have to offer are most likely to be successful. Publishing the life histories of some of the earliest nurses is likely to encourage respect for their courage and determination. Given societal realities, involvement of all nurses is unlikely and those in powerful positions are likely to continue to be most influential.

Consciousness of the meaning of Primary Health Care and appreciation of nursing knowledge and skill should lead to dialogue on the potential nursing contributions to both health care and to the larger society. Within a communicative framework, possible goals could be articulated and debated within the nursing profession with input sought from community groups and other health professionals. While consensus may be desirable, it is unlikely to be achieved if nursing participation is truly representative of the entire nursing body. Issues related to the scope of professional nursing practice in Primary Health Care are likely to be the most controversial. Unless government positions for professional nurses are created at the health post level, they are unlikely to become highly influential in Primary

Health Care as they will be blocked from developing the experiential base from which real change and innovation could occur. I believe that a health practitioner with a broad knowledge base and excellent communication skills is needed at the health post level or the principles of PHC will never be actualized. Certificate level nurses, supervised by PHNs educated to the bachelor level, could assume this role. Whether these professional nurses would be best utilized in a purely health focused position or whether they should incorporate a curative function is debatable and would make a good research question.

Current initiatives to increase professional control and accountability by seeking political legitimation with regard to requiring registration and requesting accreditation of hospitals and institutions for nursing education are based on Western models. Professional control replicates hierarchies while professional accountability can enhance standards. Nurses in Nepal are faced with the prospect of carving out a niche for themselves in PHC or of having their potential contributions in community health ignored. Political structures are changing and this is an opportune time to lobby for change. Decisions made at this time could guide the direction of professional nursing for many years. Ethical and nursing practice standards could be powerful forces in conceptualization of the accreditation process. Institutional policies with regard to evaluation and supervision could be influenced. Nursing could take leadership in these areas.

The professional association could also become an umbrella organization for collection of data on nurses working outside of hospitals, the range of their activities and the indicators of effective interventions. Funding would be needed for this activity and for any demonstration projects. Projects conceptualized and administrated by nurses, if successful, could raise the image of nurses and, if publicized, increase the visibility and credibility of the profession. Nurse-run projects could incorporate the skills of other health workers and model partnership, collaborative and multidisciplinary ventures. I would highly recommend that a nurse researcher with a background in action research be employed either by the professional association or by the Ministry of Health to facilitate and evaluate such projects. Alternatively, an international nongovernmental organization could be approached to either fund such a person or create such a position. A follow-up study of male graduate nurses could also be initiated in order to empirically evaluate the decision to stop admitting male students to nursing programs.

Control of financial resources is crucial to planning and implementing programs. Except in nursing education and some NGO positions, nurses seem to have little discretionary power with regard to health care budgets. Dependence on doctors and administrators is fostered and innovation and accountability may be inhibited. Few co-researchers perceived the likelihood or necessity of hospital matrons receiving control of nursing budgets in the near future. I would recommend, however, that thought be given to projects, community and hospital, in which nurses are taught to assume budgetary responsibility and that evaluation of such projects be conducted.

The Societal Level

Thought needs to be given to the expansion and maintenance of physical structures which will improve the living and working conditions of health personnel, particularly in rural areas. One co-researcher spoke of the intent to establish service centres, including health, education and banking services, at each ilaka. Such an initiative would increase the likelihood of nurses with young children agreeing to such postings and increase opportunities for the employment of spouses.

Supervision and evaluation of personnel is difficult in a social milieu where ascriptive characteristics have often determined opportunities and where efficiency is not as valued as interpersonal relationships. Indirect expressions of displeasure are more acceptable than confrontation. What may be needed are clear policies and mechanisms for rewarding excellence. This cannot be achieved in a system where decisions regarding promotion and other highly valued opportunities are made in Kathmandu. Decentralization of power is essential. When administrators have little authority but much responsibility, morale is likely to be low and motivation to provide effective leadership may be lacking. Without penalties for incompetence and corruption, problems with distribution of supplies are likely to continue.

Security for female staff working in rural areas needs attention. The creation of the "helper of ladies" position is an excellent idea. A hostel for female staff, perhaps including health and education sector workers, would be another approach. Accepting that women should not be posted to rural areas because of cultural barriers perpetuates the problem of women's status in Nepalese society. Active women, in responsible positions, are needed as role models for young girls. Women's health is not likely to improve in a system dominated by men. If women health professionals are accorded respect by their colleagues and by government initiatives, their image is likely to improve in the view of the general population. If nurses as a group take a stand against discrimination based on caste or ethnicity, they could become an influential group in changing societal norms which have been perceived as barriers to development.

As a group of professional women, nurses also have a responsibility to look beyond the boundaries of their own profession. Their education and experience provide them with valuable insight into many social issues. Legislation affecting women, children and the poor may benefit from their expertise. Poverty alleviation strategies may be strengthened by their input. Nurses with young families may lack the time and energy for much involvement but there are nurses with fewer responsibilities. Social action could be incorporated into criteria for faculty positions thus legitimating release time for community activities perceived as beneficial to development of the nursing profession or of the country.

The International Level

Severe financial constraints are likely to persist in Nepal. NGOs are likely to remain important contributors to health and development efforts. Where feasible, they should be encouraged to employ Nepalese nurses in service and administrative roles and provide them with opportunities to plan, implement and evaluate programs. Nurses employed in government positions can take up to two years of leave in order to pursue other interests. Perhaps nurses interested in community development or involved in teaching community nursing could rotate through such positions as part of a plan to strengthen the experiential base of practitioners and faculty.

International agencies could also stipulate nursing involvement in decisions about how aid money is to be distributed within the health sector. They could refuse to negotiate with committees composed entirely of doctors and male bureaucrats and could also facilitate the inclusion of women and nurses in discussion of issues. As effective PHC requires intersectoral collaboration and multidisciplinary input, it is important that the opinions of all players be valued. There are Nepalese nurses with the background and ability to make substantial contributions.

Finally, the partnership model of international consultation and collaboration offers exciting possibilities. Professional associations, educational institutions and health care facilities in Nepal may form partnerships with those in other countries to mutually engage in research, institution building or educational opportunities. Funding for such endeavour may be available in the more affluent countries or from international organizations. International dialogue has benefits for everyone. Participation at international conferences and professional meetings could be built into funding proposals to ensure attendance by nurses from the less affluent countries.

Implications for Nurse Consultants

How may insights emerging from this case study sensitize nurses engaged in international endeavour? As a nurse with clinical, teaching and research experience in the Canadian context, I found myself identifying very strongly with many of the issues identified by Nepalese co-researchers. Standards of education and practice and definition of nursing roles were only two issues which resonated with my own experience. Their struggle for increased autonomy and participation in shaping the direction of health care in Nepal resonated with the struggles of Canadian nurses. As interviews progressed, my feelings of connectedness with the nurse co-researchers increased and my obligation to depict their concerns as accurately as possible became a strong moral imperative. My caring became less generic and more specific. Was I losing objectivity? This was not my first experience in a less developed country. In the 1970s I spent slightly more than three years teaching nursing in Papua New Guinea. How much did that experience shape my perceptions during data collection in Nepal? These are real issues when critiquing the quality of any research endeavour. They are important.

Connections to Feminist Thought

As I was writing this final chapter, one of my committee members directed my attention to the book Women's Ways of Knowing: The Development of Self, Voice, and Mind (Belenky, Clinchy, Goldberger & Tarule, 1986). After indepth interviews with 135 women, these researchers identified five "ways of knowing that women have cultivated and learned to value, ways we have come to believe are powerful but have been neglected and denigrated by the dominant intellectual ethos of our time" (preface, before numbered pages). These ways of knowing have been categorized, in implied levels of development, as silence, received knowledge, subjective knowledge, procedural knowledge and constructed knowledge. It is the category of constructed knowledge that has relevance for examining the scientific merit of this study. The following passages seem appropriate:

> All knowledge is constructed, and the knower is an intimate part of the known. (p. 137)
>
> Ultimately all constructivists understand that answers to all questions vary depending on the context in which they are asked and on the frame of reference of the person doing the asking. (p. 138)

In the words of one of their co-researchers:

> In science you don't really want to say that something's true. You realize that you're dealing with a model. Our models are always simpler than the real world. The real world is more complex than anything we can create. We're simplifying everything so that we can work with it, but the thing is really more complex. When you try to describe things, you're leaving the truth because you're oversimplifying. (p. 138)

Integration of subjective and objective perspectives appears to be an integral part of women's "ways of knowing". Acknowledgement that this has occurred during the research process may be perceived as a strength rather than a weakness. Recognition of the limits of description allows one to acknowledge the complexity of specific questions and their context. Nurses engaged in international consultations must recognize that their interpretation of context will always be inadequate. Collaboration with local nurses, using a full partnership model, is essential.

What insights did I derive from my collaboration with the nurse co-researchers? Much of my literature review on nurses and Primary Health Care focused on the opportunity for nurses to take the leadership or guiding role. The Nepalese nurse co-researchers were much more interested in partnership, collaboration and consultation in the decision-making process and in the clinical setting. Reflection on the philosophy of Primary Health Care led me to the conclusion that they are right. Talking of leadership in a social justice and participatory model of health care is contradictory. Nursing leadership would replace one hierarchical structure with another and all hierarchical structures reflect a conceptualization of power as domination. The feminist conceptualization of power as enablement is more congruent with the stated principles of Primary Health Care. In "Territory", the feminist poet Natasha Josefowitz states:

> Are you more if I'm less?
> Do I breath your air
> or fly in your space?
> When I take up more room,
> do you become constrained?
> Do you value me more
> when I'm beholden to you?
> Do you value me less
> when I'm free and I soar?
> Are you less if I'm more?
> (Josefowitz, 1983, p. 74)

While this poem was conceived as revealing of gender relations, can it not be perceived as a description of all power relations be they gender, class, professional, ethnic or international? What feminist scholarship seems to offer is an opportunity to redefine power from an image of conflict and domination to an image of consensus and partnership. In her historical analysis of Woman as Healer, Achterberg (1991) describes nursing as a profession in transition. Her reference to the crisis in health care in the United States of America seems appropriate for many contexts:

> The current time is an era of crisis, characterized by financial exigencies and demands for a different type of health care than is being delivered in this country. Women healers find themselves at a double threshold of danger and opportunity, the twins born of crisis. Never before have women been faced with such challenges, nor has there been so much hope that they might creatively participate in the design of the future. (p. 186)

As I am writing this conclusion, I wonder if READINESS is really the core concept defining nursing efficacy. Perhaps VOICE would better define the relationships among concepts. More case studies in different contexts are necessary to refine, redefine and link concepts.

What is clear is that the knowledge, skills and attitudes needed to implement Primary Health Care effectively are complex. An instrumental approach will not be successful. A health practitioner with flexibility and broad educational and experiential background is needed. I am reminded of the metaphor used by a Nepalese woman to describe the difference between a man and a woman. In her story, a woman is like paper money and a man is like a coin. Paper money disintegrates in water while a coin remains whole. Thus the man is perceived as stronger. There is another way to interpret the metaphor. Paper is more flexible than metal. Flexibility is essential in a rapidly changing society. It is also a prerequisite for facilitation of community development and for effective collaboration in a multidisciplinary team. Initiatives in nursing education in Nepal, allied with the personal experiences of these predominantly female health professionals, may place them in a unique position from which creative and innovative strategies to move towards Health For All may be planned and implemented. Institutional structures designed to facilitate development depend on skilled human agents for successful implementation.

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APPENDIX I

Declaration of Alma-Ata

Declaration of Alma-Ata
(World Health Organization, 1988b, pp. 7-10)

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I.

The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II.

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III.

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV.

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V.

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI.

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII.

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injury; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development,

in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII.

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX.

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X.

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

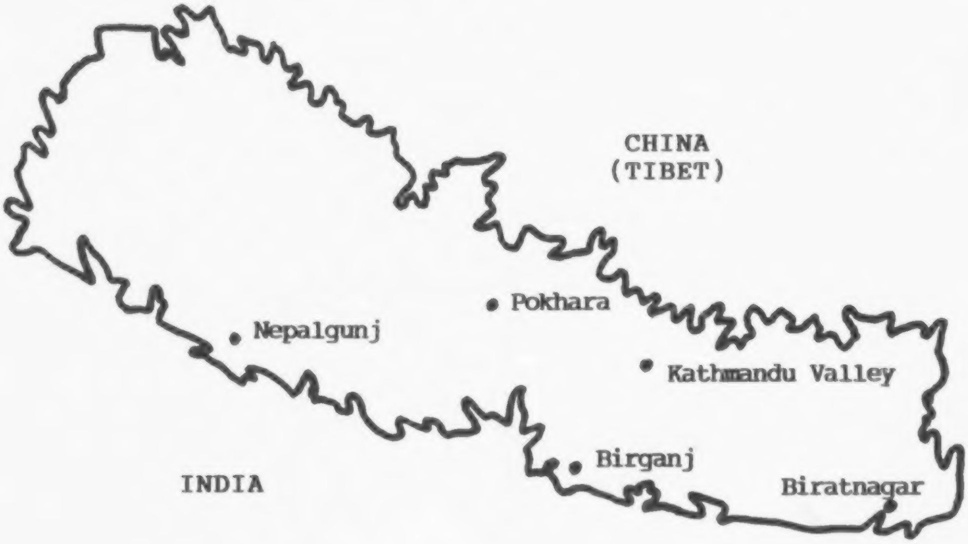
***

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

APPENDIX 11

Map Indicating the Location of Nursing Campuses in Nepal

Map Indicating the Location of Nursing Campuses in Nepal


CHINA
(TIBET)
Pokhara
Nepalgunj
Kathmandu Valley
Birganj
Biratnagar
INDIA

Kathmandu Valley
- Maharajgunj Nursing Campus
- Lalitpur Nursing Campus
- Bir Hospital Nursing Campus

Central Hills
- Pokhara Nursing Campus

Terai
- Biratnagar Nursing Campus
- Birganj Nursing Campus
- Nepalgunj Nursing Campus

APPENDIX III

Questionnaire for Certificate Level Student Nurses

IDENTIFICATION NUMBER: ________________

Questionnaire for Certificate Student Nurses

The purpose of this questionnaire is to gather information about student nurses in Nepal in terms of their backgrounds and what type of work they want to do after graduation. Please answer the questions as honestly as you can. Please ask if there are questions which you do not understand.

Background Questions

1. What is your age? ______ years

2. What is your gender? ______ female _____ male

3. Are you married? _____ yes ______ no

4. Do you have any children? ____ yes ____ no

5. What is your religion?
___ Hindu ___ Buddhist ___ Muslim ___ Christian
___ Other

6. To what ethnic group(s) do you belong?
____

7. What language(s) do you speak?
____

8. What language(s) do you read?
____

9. What language(s) do you write?
____

10. How much education did you have before you came into nursing?
___ less than class 10 ___ class 10 ___ more than class 10

11. If you had more than class 10 education or were working at a job before you became a student nurse, please write what you were doing.

____

12. What kind of school did you attend in high school?
____ general school
____ boarding school - day scholar ___
- residential scholar ___

13. Did you live with your family (parents) when you were going to high school? ____ yes ____ no

14. When you were in high school, did the house your family lived in have electricity? ____ yes ____ no

15. When you were in high school, where did your family get drinking water?
____ from a tap in the house ____ from a tap outside
____ from a stream or river ____ well ____ other

If you said other, please describe how your family got water.

____

16. When you were in high school, what kind of sanitation facilities did your family have?
___ indoor flush toilet ___ indoor toilet that did not flush
___ pit latrine ___ other

If you said other, please describe the type of sanitation facilities used.

____

17. Where did your family live when you were in high school?
____ a city (Kathmandu, Patan or Bhaktapur)
____ a district administrative centre (a regional town)
____ a village near a road
____ a village less than a one day walk from a road
____ a village that was a 1 to 2 day walk from a road
____ a village that was more than 2 days' walk from a road
____ India or other country outside Nepal

18. How much education did your mother have?
____ none ____ went to primary school
____ went to high school ____ completed high school
____more than high school

19. How much education did your father have?
____ none ____ went to primary school
____ went to high school ____ completed high school
____ more than high school?

20. How many brothers do you have? ____

21. How many sisters do you have? ____

Questions about what you want to do after graduation (You may answer these questions in English or Nepali)

22. What made you decide to become a nurse?

23. In which year of your program are you?
___ first ___ second ___third

24. What kind of nursing work do you want to do when you first graduate from nursing?

25. What do you want to be doing two years after graduation from nursing?

26. What do you want to be doing five years after graduation from nursing?

27. What do you want to be doing ten years after graduation from nursing?

28. What would be the good things about working in a rural area?

29. What would be the bad things about working in a rural area?

30. What do you think the role of nurses in Primary Health Care should be in Nepal?

31. Do you have any other information that you think might be useful for this research?

THANK YOU FOR YOUR ASSISTANCE

APPENDIX IV

Questionnaire for Baccalaureate Level Student Nurses

IDENTIFICATION NUMBER:________________

Questionnaire for Baccalaureate Student Nurses

The purpose of this questionnaire is to gather information about student nurses in Nepal in terms of their backgrounds and what type of work they want to do after graduation. Please answer the questions as honestly as you can. Please ask if there are questions which you do not understand.

Background Questions

1. What is your age? ______ years

2. What is your gender? ______ female _____ male

3. Are you married? _____ yes _____ no

4. Do you have any children? ____ yes ____ no

5. What is your religion?
___ Hindu ___ Buddhist ___ Muslim ___ Christian
___ Other

6. To what ethnic group(s) do you belong?
____

7. What language(s) do you speak?
____

8. What language(s) do you read?
____

9. What language(s) do you write?
____

10. How much education did you have before you came into nursing?
____ less than class 10 ____ class 10
____ more than class 10

11. If you had more than class 10 education or were working at a job before you became a student nurse, please write what you were doing.

____

12. What kind of school did you attend in high school?
____ general school
____ boarding school - day scholar ___
- residential student ___

13. Did you live with your family (parents) when you were going to high school? ____ yes ____ no

14. When you were in high school, did the house your family lived in have electricity? ____ yes ____ no

15. When you were in high school, where did your family get drinking water?
____ from a tap in the house ____ from a tap outside
____ from a stream or river ____ well ____other

If you said other, please describe how your family got water.

---

16. When you were in high school, what kind of sanitation facilities did your family have?
__ indoor flush toilets __ indoor toilet that did not flush
__ pit latrine __ other

If you said other, please describe the type of sanitation facilities used.

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17. Where did your family live when you were in high school?
____ a city (Kathmandu, Patan or Bhaktapur)
____ a district administrative centre (a regional town)
____ a village near a road
____ a village less than a one day walk from a road
____ a village that was a 1 to 2 day walk from a road
____ a village that was more than 2 days' walk from a road
____ India or other country outside Nepal

18. How much education did your mother have?
____ none ____ went to primary school
____ went to high school ____ completed high school
____ more than high school

19. How much education did your father have?
____ none ____ went to primary school
____ went to high school ____ completed high school
____ more than high school

20. How many brothers do you have? ____

21. How many sisters do you have? ____

Questions about your nursing career (You may answer these questions in English or Nepali)

22. From which school of nursing did you graduate?

23. What year did you graduate? 19___

24. Please describe your work experience in nursing. State what kind of work you have done, how long you did it and whether you worked in an urban or rural place. If you need more space, please write on the back of the form.

25. What made you decide to do a baccalaureate degree?

26. In which year of your program are you?
____ first ____ second

27. What do you want to do when you graduate?

28. What do you think the nursing role in Primary Health Care in Nepal should be? Please give some examples of the work which you think nurses could do.

29. What do you think are the things that will allow nurses to be important health care workers in Primary Health Care in Nepal?

30. What do you think are the things that will make it difficult for nurses to be important health care workers in Primary Health Care in Nepal?

31. What other information do you wish to share which you think might be useful for this research?

THANK YOU FOR YOUR ASSISTANCE

APPENDIX V

Questionnaire for Nursing Faculty

IDENTIFICATION CODE: ____________________

Questionnaire for Nursing Faculty

The purpose of this questionnaire is to gather information about nurses and Primary Health Care in Nepal. Please answer the questions as honestly as you can. Please ask if there are any questions which you do not understand.

Background Questions

1. What is your gender? ____ female ____ male

2. What is your marital status? __single __married __widowed __divorced

3. Do you have any children? ___ yes ___ no

4. Are you Nepalese? ___ yes ___ no

5. If you answered yes to #4, to what ethnic group(s) do you belong?

____

6. If you answered no to #4, what nationality are you?

____

7. What is your religion?
___ Hindu ___ Buddhist ___ Muslim ___Christian
___Other

8. What language(s) do you speak?

____

9. What language(s) do you read?

____

10. What language(s) do you write?

____

Questions about your nursing career (You may answer in English or Nepali)

11. Please list your nursing qualifications (certificates/diplomas/degrees) and where and when you obtained them.

Qualification	Educational Institution	Country	Year

12. What other educational qualifications do you have?

13. Please describe your clinical nursing experience. Do not include your teaching experience.

14. How long have you been in your present faculty position?
___ years

15. Please describe any other teaching or administrative positions which you have held in nursing.

16. Were you involved in the process of developing the curriculum which was implemented in 1987? Please answer yes even if your involvement was limited to going to a workshop where you were asked for your opinion about the new curriculum. ___ yes ___ no

17. If you were teaching nursing in Nepal before implementation of the new curriculum, how has the integration of the Primary Health Care concept into nursing education changed your job?

18. What do you think the nursing role in Primary Health Care in Nepal should be?

19. What do you think are the forces promoting nursing involvement in Primary Health Care in Nepal?

20. What do you think are the barriers to nursing involvement in Primary Health Care in Nepal?

21. What other information do you wish to share which you think might be useful for this research?

THANK YOU FOR YOUR ASSISTANCE

APPENDIX VI

Questionnaire for Generation of Identification Codes

SUBJECT IDENTIFICATION CODE

PURPOSE:
There is no reason for anyone to know which questionnaire belongs to each student or faculty member. It may be useful, however, to be able to connect this research with future research in which you agree to participate. Therefore, you are being asked to create your own identification code from information which should not change with time. You should get the same code by being asked to answer the same questions at any time in the future.

DIRECTIONS:

1. Please CIRCLE the letter below that is the same as the first letter of your mother's first name.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

2. Please CIRCLE the letter below that is the same as the first letter of your father's first name.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

3. How many OLDER BROTHERS do you have? If you have no older brothers, please answer with a zero (0). ____ brothers

4. How many OLDER SISTERS do you have? If you have no older sisters, please answer with a zero (0). ____sisters

5. Does YOUR own FIRST name begin with a letter in the FIRST half of the alphabet (A to M)? ____ yes ____ no

6. Please CIRCLE the letter below that is the same as the first letter of your MIDDLE name (if you have no middle name, circle N).

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

APPENDIX VII

Consent Form for Questionnaire Respondents

Informed Consent for Questionnaire Respondents

Project Title: Nurses and Primary Health Care in Nepal

Researcher: Linda Ogilvie, R.N., M.Sc.N.
PhD student
Department of Educational Foundations
University of Alberta
Edmonton, Alberta, Canada

The purpose of this research is to look at the context in which the change to Primary Health Care is happening in Nepal. Focus will be on the role of nurses in the process. If you agree to take part in this project, you will be asked to answer some questions. It will take less than one hour. You will make your own identification code from personal information that the researcher will not have. The researcher will not share your answers with anyone else in Nepal except for assistance in translating answers given in Nepali into English.

This is to certify that I, ______________________________
(print name)
hereby agree to take part in the above named project. I understand that no one will be able to identify my answers in any report or presentation of the findings. I also understand that I may choose not to be a part of this project.

______________________ ______________________ ______
Signature Witness Date

APPENDIX VIII

Consent Form for Interview Co-researchers

Informed Consent for Interview Co-Researchers

Project Title: Nurses and Primary Health Care in Nepal

Researcher: Linda Ogilvie, R.N., M.Sc.N.
PhD student
Department of Educational Foundations
University of Alberta
Edmonton, Alberta, Canada

The purpose of this research is to explore the context in which the transition to Primary Health Care is occurring in Nepal. Focus will be on the involvement of nurses in the process. If you agree to participate in this project, you will be interviewed by the researcher for approximately one hour on one or more occasions. The interview(s) will be audio-taped.

This is to certify that I, ______________________________
(print name)
hereby agree to participate in the above named project. I give permission to be interviewed and for the interviews to be recorded. I understand that, at the completion of the project, the tapes will be erased. There will be no information that will identify me in presentations or published reports of this research. I understand that I may review the transcripts of the taped interviews and that I may choose not to participate in this project or to withdraw my participation at any time without penalty. Questions about the research have been encouraged and my questions have been answered to my satisfaction.

______________________	______________________	______
Signature	Witness	Date